Healthy Enough to Enter?
– Exploring the nexus of the body and the border through South African visa medical requirements

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Acknowledgements

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Abstract

Visitors to South Africa wishing to stay in the country for longer than three months are required to submit a medical report which makes room for a host of physical and mental “defects”, including leprosy, venereal disease, trachoma, disabilities and mental health disorders ranging from addictions to epilepsy. The form appears to be an object that points to a multiplicity of interpretations as well as inconsistencies. It is a piece of paper encountered by several actors key to the immigration process – policy makers, visa applicants, doctors and lawyers – and through its use, showcases the tensions that exist between these sites. Furthermore, as a mandatory visa document, the medical form directs us to examine the relationship between the individual body and the exercise of state power.

Keywords:

Health securitization, borders, visas, health, disease, migration, south africa
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<tbody>
<tr>
<td>DHA</td>
<td>Department of Home Affairs</td>
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<tr>
<td>DIRCO</td>
<td>Department of International Relations and Cooperation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICD</td>
<td>International Classification of Diseases</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>SA</td>
<td>South Africa</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>US</td>
<td>United States</td>
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<td>WHO</td>
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Introduction

Visitors to South Africa wishing to stay in the country for longer than three months are required to submit a medical and radiological report with their visa application, declaring them free of tuberculosis (TB) and “generally in a good state of health”. The completion of the radiological report requires the applicant to undergo a chest x-ray, while the medical report needs to be filled in and signed off by a doctor. Indeed, this medical form makes room for a host of physical and mental “defects”, including leprosy, venereal disease, trachoma, disabilities and mental health disorders ranging from addictions to epilepsy.

The form uses what can be viewed as insensitive language – for example, “physically defective”. With no definition provided, this use of language also seems particularly vague. Then there is the inclusion of what appears to be an extensive range of mental disorders that need to be declared, ranging from depression to epilepsy. The specific diseases listed on the form also appeared to be outdated, and not at all the kinds of things that would match the country’s epidemiological profile. If one was considering the screening of migrants for diseases that are rife in South Africa in order to prevent further infection, leprosy would most likely not be the first condition that came to mind.

Preliminary research indicated that people had very different experiences with this form:

_I just went to my family GP ...who knew my medical history and just completed the form, sign[ed] and stamp[ed] it._ [Applicant]

_The tests are pretty straightforward. The doctor just asks you some very basic questions about your health and then just confirms if you are healthy enough to move abroad... Don’t worry, they don’t use needles or do anything invasive._ [Applicant]

_The medical report you literally get your GP to sign (to say you’re not mental or have VD:)!_ [Applicant]

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1 Throughout this thesis, when reference is made to “the medical form”, I am speaking about this specific medical report as seen in Appendix A
2 An infection causing blindness (WHO, 2019a)
3 Venereal disease
It seemed, then, that the form may not be as important as initially thought, if doctors were just signing it off without actually testing for the listed conditions. However, other medical centres dedicated specifically to visa medical checks listed tests for illnesses such as hepatitis and HIV – which seemed to be going further than the requirements of the form (IPSA 2019). It is unclear whether what is written on the form would impact someone’s visa application if they did, in fact, have some kind of physical disability or mental illness.

Indeed, there appears to be no apparent conversation around this document, compounded by a seeming lack of information around the use of the form. It is significant in that it is a required part of the South African visa process and you need to “pass” it, but insignificant in that applicants and their doctors do not appear to take it very seriously. The form thus appears to be an object that points to a multiplicity of interpretations as well as inconsistencies. It is a piece of paper encountered by several actors key to the immigration process – policy makers, visa applicants, doctors and lawyers – and through its use, showcases the tensions that exist between these sites. Furthermore, as a mandatory visa document, the medical form directs us to examine the relationship between the individual body and the exercise of state power. How then are South African border politics enacted on the terrain of the body?

Research aim and questions

The aim of this thesis is to understand and explore the discourse between the body and the border by examining how this particular medical form is interpreted by and enacted across multiple sites. Using the medical form as the entry point, I will examine and attempt to answer:

- How is the medical form actually used in the South African context?
- How are different actors (medical, legal, personal) reasoning around this specific template?
- What kind of issues arise through the form’s use? What does it do?
- What kind of bodies are constructed through the use of the form?
- How are the body and the border enacted together?
This thesis will follow the following outline: in the research context chapter I will provide relevant background information on my chosen topic, in addition to previous research that has informed my thinking. This will be followed by the methodology chapter, explaining what was done in order to conduct and produce the research, and why. I will then introduce the theoretical concepts that pertain to the issues dealt with in this thesis, followed by the analysis section, where I will attempt to answer some of the questions outlined above. Finally, my concluding chapter will contain a discussion about the ramifications of what has been discovered through the research investigation that has taken place.

Research Context

For ease of reading, this section has combined both previous research and relevant background information under thematic headings. I will start by taking an in-depth look at the South African context, in terms of immigration laws, the medical form which I am problematizing and the state of the public health system. This will be followed by a discussion of health checks in the current global context. I will then introduce and explain the WHO International Health Regulations, which play a role in informing how states should respond to global disease outbreaks and the health of both locals and travellers. There will then be a brief outline of the historical context of immigrant health checks, covering state methods of exclusion on health grounds, and the persistent association between foreigners and disease. This is so that the reader has a clearer idea of the reasoning behind these kinds of checks, as well as how state power has been used to control the movement of bodies. Finally, there will be a section relating to border politics, including brief discussions relating to visa regimes, contemporary examples of biometrics used for immigration purposes and South Africa’s context of xenophobia which informs the state’s response to immigrants.
The South African Context

All visitors who are visiting South Africa for longer than three months are required to submit radiological and medical reports as part of their visa application. These include Temporary Residence Visas covering Business Visas, Work Visas, Study Visas, Retired Persons’ Visas and Relatives’ Visas, as well as the application for Permanent Residency. These forms are not required for refugees or asylum seekers, unless it is a refugee applying for their permanent residence after five years, because they are entering the country under the Refugee Act, rather than the Immigration Act, and the requirements differ (DHA, 2016a).

First-time visa applicants are not allowed to apply from within South Africa – they have to do so from a South African embassy, mission, consulate or VFS office in their country of origin or country of residence. If there is no South African diplomatic representative in their country of origin or country of residence, then the applicant may go to a South African diplomatic representative in a neighbouring country (DHA 2019). They will need to bring with them a number of different supporting documents, depending the type of visa they are applying for.

What does the law say?

Sections 29 and 30 of the South African Immigration Act No. 13 of 2002 outline the list of prohibited and undesirable persons respectively. Selected quotes relating to physical and mental health in the law are as follows:

29. (1) The following foreigners do not qualify for a temporary or a permanent residence permit:
   (a) those infected with infectious diseases as prescribed from time to time:

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4 The terms “visa” and “permit” are used interchangeably in Department of Home Affairs documents and websites. Indeed, the website notes “On entry to South Africa, a visa is considered to be a visitor’s permit,” (DHA 2016a).

5 VFS Global is the company outsourced by the South African government to process some diplomatic administrative tasks such as temporary resident visas and permanent resident permits (VFS Global, 2019).

6 (xxix) “prescribed” means provided for by regulation, the verb “to prescribe” has a corresponding meaning and “prescribed from time to time” refers to section 7(2) – Immigration Act of 2002.
30. (1) The following foreigners may be declared undesirable by the Department as prescribed
(a) anyone who is or is likely to become a public charge:
(c) anyone who has been judicially declared incompetent:

According to the Department of Home Affairs’ website, you may be considered a prohibited person if:

You are infected with infectious diseases that can spread easily. These diseases include cholera; pestilence, yellow fever and any other diseases as determined by the Department of Health from time to time. (DHA, 2016b)

Immigration Regulations (Government Notice 413 of 22 May 2014) derived from the Immigration Act provide further insight as to where a list of the prescribed diseases can be found:

26. (1) The diseases or viruses contemplated in section 29(1)(a) of the Act are those referred to in the regulations promulgated under the International Health Regulations Act, 1974 (Act No. 28 of 1974), and any other disease or virus rendering a person inadmissible as may be determined by the Department of Health from time to time in terms of the applicable legislation.

The aforementioned International Health Regulations Act No. 28 of 1974 is a legal document formulated in response to the International Health Regulations that were adopted by the World Health Assembly (the decision-making body of WHO) in 1969. In essence, the South African regulations outline procedures to ensure port health, covering the arrival and departure of ships, airplanes, trains and road vehicles, as well as the procedure for notifying WHO of a “disease subject to the Regulations”.

These “diseases subject to the Regulations”, also referred to as “quarantinable diseases” are listed in the regulations as “cholera, including cholera due to the eltor vibrio, plague, smallpox, including variola minor (alastrim), and yellow fever”. The regulations make no specific mentions of anything relating to visas, but rather describes mandatory quarantine, surveillance and medical treatment for those carrying the specified illnesses who are arriving into the country.
The Medical Report

As outlined in the Immigration Regulations of 2014, the "medical report" refers to:

…a report by a registered medical practitioner with regard to the applicant’s general state of health, detailing any medical condition he or she suffers from, which report shall not be older than six months at the time of its submission.

There is a specific template for medical report which needs to be filled in, which can be seen at the end of this thesis in Appendix A. Unlike several countries such as the US and Australia, South Africa does not make use of panel physicians. As such, a visa applicant can visit any registered doctor, in whichever country they happen to be applying from.

According to the report, the doctor is required to confirm that the candidate is:

- Not mentally disordered or physically defective in any way
- Not suffering from leprosy, “venerals” disease, trachoma, or other infections or contagious condition
- Generally in a state of good health

Furthermore, the doctor needs to list any “defects” that they observe – referring to disorders, diseases and disabilities. They are requested to provide details on the seriousness and prescribed or recommended treatment for these. In addition, the form notes that even though the candidate may be in a state of good health at the time of examination, the doctor should still mention any conditions that the applicant has or has had that may potentially recur.

When it comes to the definition of “mentally disordered”, the form provides a list of ICD-9 codes at the bottom of the form which it constitutes as mental disorders. These include psychoses, additions, personality disorders, neuroses, mental retardation and epilepsy.

Panel physicians are medical practitioners authorized by a particular country’s immigration department or other relevant authority to complete medical reports for visa applicants.

This appears to be a typographical error on the form – the correct word is “venereal”.
<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Condition</th>
<th>ICD-9 Code</th>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td>290</td>
<td>Dementias</td>
<td>327</td>
<td>Organic sleep disorders</td>
</tr>
<tr>
<td>291</td>
<td>Alcoholic Psychoses</td>
<td>330</td>
<td>Cerebral degenerations usually manifest in childhood</td>
</tr>
<tr>
<td>292</td>
<td>Drug Psychoses</td>
<td>331</td>
<td>Other cerebral degenerations</td>
</tr>
<tr>
<td>293</td>
<td>Transient organic psychotic conditions</td>
<td>332</td>
<td>Parkinson's disease</td>
</tr>
<tr>
<td>294</td>
<td>Other organic psychotic conditions</td>
<td>333</td>
<td>Other extrapyramidal disease and abnormal movement disorders</td>
</tr>
<tr>
<td>295</td>
<td>Schizophrenic psychoses</td>
<td>334</td>
<td>Spinocerebellar disease</td>
</tr>
<tr>
<td>296</td>
<td>Affective psychoses</td>
<td>335</td>
<td>Anterior horn cell disease</td>
</tr>
<tr>
<td>297</td>
<td>Paranoid states</td>
<td>336</td>
<td>Other diseases of spinal cord</td>
</tr>
<tr>
<td>298</td>
<td>Other nonorganic psychoses</td>
<td>337</td>
<td>Disorders of the autonomic nervous system</td>
</tr>
<tr>
<td>299</td>
<td>Psychoses with origin specific to childhood</td>
<td>338</td>
<td>Pain</td>
</tr>
<tr>
<td>300</td>
<td>Neurotic disorders</td>
<td>339</td>
<td>Other headache syndromes</td>
</tr>
<tr>
<td>301</td>
<td>Personality disorders</td>
<td>340</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>303</td>
<td>Alcohol Dependence</td>
<td>341</td>
<td>Other demyelinating diseases of central nervous system</td>
</tr>
<tr>
<td>304</td>
<td>Drug Dependence</td>
<td>342</td>
<td>Hemiplegia and hemiparesis</td>
</tr>
<tr>
<td>310-315◊</td>
<td>All forms of mental retardation</td>
<td>343</td>
<td>Infantile cerebral palsy</td>
</tr>
<tr>
<td>320</td>
<td>Bacterial meningitis</td>
<td>344</td>
<td>Other paralytic syndromes</td>
</tr>
<tr>
<td>321</td>
<td>Meningitis due to other organisms</td>
<td>345</td>
<td>Epilepsy and recurrent seizures</td>
</tr>
<tr>
<td>322</td>
<td>Meningitis of unspecified cause</td>
<td>346</td>
<td>Migraine</td>
</tr>
</tbody>
</table>

◊ There is a discrepancy between two of the code categories listed on the form and the ICD-9 codes, which will be discussed in the analysis chapter.
<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>323</td>
<td>Encephalitis, myelitis, and encephalomyelitis</td>
</tr>
<tr>
<td>324</td>
<td>Intracranial and intraspinal abscess</td>
</tr>
<tr>
<td>325</td>
<td>Phlebitis and thrombophlebitis of intracranial venous sinuses</td>
</tr>
<tr>
<td>326</td>
<td>Late effects of intracranial abscess or pyogenic infection</td>
</tr>
<tr>
<td>347</td>
<td>Cataplexy and narcolepsy</td>
</tr>
<tr>
<td>348</td>
<td>Other conditions of brain</td>
</tr>
<tr>
<td>349</td>
<td>Other and unspecified disorders of the nervous system</td>
</tr>
</tbody>
</table>

(Figure 1: Table listing the ICD-9 codes and their associated conditions listed on the form as constituting “mentally disordered”. Note that in the interests of space, this table does not include the subcategories that appear after the decimal point, e.g. 300.3 – Obsessive Compulsive Disorders. There are no ICD-9 codes for 328 and 329, so the numbering jumps from 327 to 330.) (Source: ICD.codes, 2019)

**The Radiological Report**

According to the Immigration Regulations of 2014, the “radiological report” refers to:

…a report by a registered radiologist certifying that the applicant has been examined and that no signs of active pulmonary tuberculosis could be detected, which report shall not be older than six months at the time of its submission;

The template for this report can be seen in Appendix B. Visa applicants are required to undergo a chest x-ray at a radiology department and the form needs to be signed off by a registered radiologist to certify that they have not detected any sign of active pulmonary tuberculosis. Pregnant women and those under the age of 12 are exempt from this process.

**South African Public Health**

There is a plethora of research into South Africa’s public health system and the country’s epidemiological profile. Knowledge of this particular context is important when it comes to understanding the responses of the interviewees in the analysis section. According to Coodavia
et al (2009:817), South Africa faces four concurrent epidemics, something which only occurs in the Southern African Development Community Region. These include poverty-related illnesses (e.g. malnutrition, infectious diseases and maternal death); non-communicable diseases (e.g. diabetes, stroke and heart disease); HIV/AIDS; and death, disabilities or injuries resulting from violence. Overall, while the country can economically be considered middle-income, its health outcomes are on par or worse than many lower income countries (ibid.).

According to Section 27 in the Bill of Rights of the South African Constitution, everyone has the right to healthcare. Furthermore, Section 4(3) of the National Health Act specifies that primary healthcare services are free, in addition to abortions, HIV and TB treatment, and services at clinics and hospitals for pregnant and breastfeeding women, as well as children under the age of six. Crucially, neither bills make any distinctions on the basis of nationality. Emergency care also needs to be provided to patients regardless of their ability to pay – they will be billed afterwards, but treatment cannot be refused (Stevenson, 2019).

South Africa has a two-tiered national health system incorporating both private and public sectors. While the spending by the two sectors is roughly equal, there is a huge disparity in the number of people they serve, with the public sector providing for around 84% of the population (Naidoo, 2012:149). (It should be noted, however, that many people use a combination of public and private services.) In essence, social class is a determinant of the level of healthcare one receives. There are also significant health inequities between different ethnic groups and sexes, as well as between provinces and within them (Coodavia et al, 2009:824). Apart from the financial disparity, the public health system is also understaffed and mismanaged, with run-down facilities and a shortage of medical resources. Overall, the state of the current system can be summarized as “unsustainable, destructive, very costly and highly curative or hospice-centric,” (Naidoo, 2012:149.).

In the public sector, services (apart from the exempt ones listed previously) are billed on a sliding scale via a means test, that is, you pay what you can for the treatment you have received (Stevenson, 2019). Undocumented members of the SADC region\textsuperscript{10}, refugees and asylum seekers, permanent residents and visitors or foreigners with study permits or temporary work permits are to be treated in the same manner as South African citizens – that is, they are subject to the sliding scale of fees. Everybody else who doesn’t fall into these categories has to pay full patient fees as set out by the government. Essentially, these would be tourists (who are

\textsuperscript{10} Angola, Botswana, Comoros, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.
more than likely to have travel insurance), private patients who happen to need a service at
government facility (who have health insurance anyway), externally funded patients, and
undocumented migrants from outside of the SADC region (Western Cape Government, 2019).
Patients are required to show some form of identification in order to receive treatment, and
sometimes also proof of income.

Many of the current problems plaguing the healthcare system are the result of past
historical factors. Colonization and Apartheid, for example, led to massive income inequalities
that still persist today, as well as racial and gender-based discrimination, the migrant labour
system and extreme violence (Coodavia et al, 2009:817). These in turn have had an impact on
the provision of healthcare services, as well as the health of the country’s inhabitants. The issues
are compounded by current macro-economic policies that favour growth over redistribution and
a failure to address the historical roots of current healthcare inequities, in addition to the
inadequate management of resources, and overall poor leadership of the health department.

Current Context: Health Checks in Other Countries

Internationally, there are numerous examples of health checks required as part of visa
application processes, depending on the country one is applying to, one’s country of residence,
and the type of visa one is applying for. This subsection provides just a brief summary of some
examples of health examinations that are required.

Applicants looking to immigrate to the US will have to undergo a physical consultation
by an authorized doctor which will “at least include examination of the eyes, ears, nose and
throat, extremities, heart, lungs, abdomen, lymph nodes, skin, and external genitalia,”
(Travel.state.gov., 2019). As for those planning to stay in New Zealand for over a year?
According to the description on the general medical form required as part of the visa
application, a doctor will “check your height, weight, mental state, hearing and vision, listen to
your heart, lungs, feel your abdomen and check your reflexes, power and the rest of your
nervous system,” (New Zealand Immigration, 2019). You will also need to submit to urine and
blood tests to complete the examination (ibid.).

Meanwhile, as part of Australia’s arsenal of health evaluations, all permanent and some
temporary visa applicants must declare their HIV and hepatitis status (Australian Government
Department of Home Affairs - Immigration and Citizenship, 2019). The country does not
necessarily deny entry based on positive results, but rather on whether you’re planning to work
in particular medical professions or have a certain viral load (ibid.). More bluntly, they further
assess whether your healthcare needs as a result of your condition would cost the government money, and whether you would need access to healthcare services that are already in short-supply, thus prejudicing access of Australian citizens (ibid.)

According to UNAIDS (2019), in 2018 at least 20 countries imposed some kind of travel restriction on people with HIV, and 59 reported compulsory testing for marriage, work or residence permits. TB x-rays are required for visas from countries ranging from the United Kingdom to Papua New Guinea, depending on your past country of residence (Saunders, 2016). China requires you to declare if you have a mental disorder, as do the already-discussed USA and Australia, to name but a few. And each European Union country has its own legal framework for dealing with “serious diseases threatening public health” when it comes to the issuing of long-term permits: for example, Luxembourg requires third country nations to submit to a medical exam within the country as part of their application for a residence permit, as does France for stays longer than three months (European Migration Network, 2013).

International Health Regulations

The International Health Regulations (IHR) are, as the name suggests, a set of regulations designed by the World Health Organization to guide the way that countries respond to disease outbreaks. More specifically, their aim is to:

…prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade. (WHO, 2005:1)

The first version of these such regulations were published in 1969 and are the same regulations upon which South Africa’s International Health Regulations Bill of 1974 is based. The 2005 WHO regulations (officially implemented in 2007) emphasise the importance of early identification, reporting and surveillance of public health emergencies. They provide guidance to states on how to identify whether what they have detected qualifies as a “public health emergency of international concern” (Wilson et al, 2008:44).

There are a number of significant differences between the old and the new versions of the IHR. Firstly, the 2005 edition does not limit the regulations to specific diseases such as the plague or cholera, but rather make use of the broader concept of a “public health emergency of
international concern” (Wilson et al, 2008:44). These are can include any “illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans” (WHO, 2005:1). Secondly, when it comes to notifying WHO of a potential outbreak, it can now be done on a confidential basis, such as by civil society actors or private sector organisations (Yuk-Ping & Thomas, 2010:452). WHO can also make use of non-official sources such as internet postings, and then seek verification from the state in question. This means that even if state officials are slow to notify WHO of a potential public health emergency, the organization can still begin to investigate and share information with the public or other member states (Wilson, 2008:44).

Once WHO has been notified of a potential outbreak, the Director-General liaises with a committee of experts to determine whether the reported event does indeed count as a “public health emergency of international concern”. If this is indeed the case, WHO will then provide the state(s) with a set of temporary and standing recommendations to help them address the outbreak. There are thirteen different measures that WHO is authorized by the regulations to recommend, including quarantine, vaccinations and mandatory medical examinations (WHO, 2005). However, the emphasis is on actions that provide protection to the public while minimizing intrusion and disruption (Wilson et al, 2008:45). If member states wish to take further action, they are permitted to do so, but within the confines of WHO conditions. In these situations, WHO aims to provide:

…proportionate responses which seek to ensure that human rights violations and hindrances to international traffic only occur when there is an actual and confirmed threat to international health of sufficient consequence to warrant such interference. (Goldfarb, 2016:792)

Indeed, there is a specific focus on responses that do not involve “unnecessary interference with international traffic and trade” (WHO, 2005:1). This is because disease outbreaks can devastate a regional economy through other countries implementing travel restrictions or outright travel bans. These disease outbreaks often occur in low-income countries who quite literally cannot afford the negative economic impact, and thus makes them reluctant to report outbreaks for fear of the financial consequences – and in turn makes it more difficult to respond to the spread of infection (Wilson et al, 2008:45-46). Economic hardship from these stigmatized countries can also facilitate irregular migration, thus compounding the problem (Goldfarb, 2016:806). By trying to minimise disruption of international traffic, that is, the movement of people, WHO is
recognizing the protection of certain human rights as part of their regulations (Goldfarb, 2016:794). In Article 3 of the IHR, it explicitly states that “The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons.” However, this is contradicted by the use of non-specific language in the document, as well as provisions for “compulsory” health measures when deemed necessary (ibid., 795).

One of the major issues with these regulations - as with many co-operative initiatives in the international sphere - is that they are legally non-binding. There is no way for WHO to actually force states to comply with them, even if they are a signatory. States may decide to take independent action against the advice of WHO, and implement travel bans or other such restrictions. There is no punishment for states who fail to comply with the regulations, such as not declaring an outbreak or exceeding the recommended measures in response (Goldfarb, 206:800; Wilson et al, 2008:44). This reveals tensions between state sovereignty with regards to issues such as border control and domestic health policy, and what Puk-Ying and Thomas (2010:451) refer to as “a post-Westphalian health order”, characterized by initiatives such as the IHR which advocate for “a moral imperative towards human and health security irrespective of state borders” (ibid.). The regulations have also been criticized for placing economic and security concerns above those of health (Wilson et al, 2008:45). Both of these issues link to the phenomenon of health securitization, which will be discussed further on in the theory chapter.

**From Past to Present: Tracing the Historical Context**

Becky Taylor (2016) provides insight into the medical examinations of immigrants at English ports resulting from Britain’s 1920 Aliens Order. Elements from her work which are relevant to this thesis include her examination of how legislation is translated into practice; the ambitions, actions and limitations of the state; and presumptions that immigrants present a health risk to the native population. Furthermore, Taylor reveals the tensions between disparate sites in this process, namely the biological and the bureaucratic. Finally, she uses a Foucauldian approach to study the power of the expanding state, its physical control of populations and this power is diffused, embodied and enacted in different spaces within societies (Taylor, 2016:518). Indeed, she notes that:

…while borders are places where state power is imposed and performed, it is equally possible that borders might see its absence or weakness, complicating or destabilising face-to-face encounters between incomes and agents of the state. (ibid., 519)
The British legislation is particularly pertinent to the South African context, as the latter was a colony of the former. The Union of South Africa was formed in 1910 as the result of an Afrikaner treaty with the British but was still under the domination of the British empire. The country only became a self-governing nation-state in 1934, and a fully sovereign republic in 1961 (Alexander, 2019).

Markel and Stern (2002), meanwhile, tackle the stereotype of “foreigners” as sick bodies in The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society. Briefly tracing the history of immigration to the US, they show how certain groups of outsiders in the US were blamed for the spread of disease – more specifically, how different groups were viewed as the culprits or alternately as acceptable bodies at different times in the past. Initially the US made distinctions between the acceptable “old” immigrants from the UK and northern Europe and the less-desirable “new immigrants” who originated from eastern, southern and central Europe. Then it was the turn of Mexican and Chinese labourers to be subjected to the prevailing race and class stereotypes, leading to more extensive and invasive tests at the point of entry. Most recently, the “whiteness” of America has been threatened by the arrival of darker-skinned immigrants from Latin America and Africa, once again stoking the same old fears of contagion and disease.

Several mechanisms were used as tools of exclusion on the grounds of health, such as: the use of medical language to frame anti-immigrant rhetoric and policies; methods of classification that served to continually exclude the most unwanted types of people; and ideologies of racism, nativism, and national security, which deemed certain bodies to be biologically inferior and prone to disease (ibid., 757-761). Apart from the physicality of the body, an immigrant’s mental state also became a matter of concern to authorities. Certain disorders were linked to a perceived failure of morality, with sufferers thought to be at risk of becoming a public charge or a social and economic drain on the state (ibid., 764).

Ultimately, the public perception of the migrant as a health threat was blown far out of proportion in relation to the actual risk that they presented (ibid., 758). However, the authors argue that these stereotypes have persisted to this day, evident in the fact that American immigration health policy only requires immigrants and visa applicants, and not citizens returning from overseas, to undergo medical examinations before setting foot in the country (ibid., 777). Markel and Stern (2002: 781) conclude that:
If any concept in this brief history of immigration and public health is antiquated, it is the idea that infectious diseases can be controlled by targeting certain populations based on apparent ethnic or national background.

In *Policies of Inclusion*, Amy L. Fairchild (2004) outlines the justifications used by the American government to allow or bar entry to immigrants based on health status, dating from the late 1800s to the so-called AIDS crisis of the very recent past. Indeed, the reasoning behind these decisions bears a similar resemblance to much of the discourse that occurs today. America’s need for immigrant labour was (and arguably still is) complemented with their wish to restrict the arrival of those who could not support themselves (ibid., 529). During the Progressive Era, citizenship was determined through one’s ability to either participate in civic or industrial life. Good citizens are working citizens. Consequently, “Chronic, debilitating disease represented the permanent inability of an immigrant to function in society: it represented dependency,” (ibid., 530).

The medical examination to determine entry provided a useful tool with which to achieve higher exclusion rates, particularly in places that were receiving a higher share of “undesirable immigrants” (ibid., 532). This was a way to protect the health of the community from the threat represented by so-called inferior races. During the peak of the AIDS crisis during the 1990s, this rhetoric again reared its ugly head, with “racial restrictions masquerading as public health policy” (ibid., 528). The subsequent ban on HIV positive travellers also served to cement the link between disease and dependency. One of the rationales behind the ban was the fear that immigrants with HIV would overburden the healthcare system, leading to a complete collapse (ibid., 533). The author explains that the ban also came at a time when the US was examining the overall burden that immigrants represented to society. As a result, to make very sure that immigrants would not rely on or partake in any of America’s social services, legislation that would withdraw access to welfare for both legal immigrants and supposedly “undeserving” citizens was proposed, although ultimately failed to pass.

Finally, Hong et al (2017) examine a contemporary case of exclusion due to health status in their paper *Refugee Policy Implications of U.S. Immigration Medical Screenings: A New Era of Inadmissibility on Health-Related Grounds*. They show how communicable diseases are fundamental in determining whether one is permitted entry to the US, but that populism and partisan ideology, rather than fact-based public health evidence, are used to influence admissibility on health-grounds.
In tracing historical changes in the US medical examination for immigrants, the authors note that the previous HIV ban ensured that the state could not be subject to criticism for “misdirecting” national resources to treat ill immigrants – in other words, the foreign sick body was again viewed as a burden, and an undeserving one at that (ibid., 4). Ironically enough, at the time the ban was instituted, the highest number of HIV/AIDS cases was in the US (ibid.).

In terms of current health risks, Hong et al (2017:6) explain the difficulties in educating people and making them aware of disease risk while accounting for the public’s perception of said risk. Factual information regarding public health often fails to convince or reassure people who are uncertain about the risks that immigrants pose, leading to negative public opinion when it comes to accepting refugees and/or foreigners (ibid., 6). These misperceptions in turn can be taken full advantage of by social media, the press and politicians, ultimately influencing legislation around this matter.

Ultimately, the authors argue that restricting admissibility on health grounds serves simply to:

…promulgate the misperception that disease burden is predominantly of foreign origin and can only be managed through border controls rather than treatment, public health education, and other preventative methods. (ibid., 10)

Border Control

The visa application form is a genre unto itself. And it’s an object lesson in miniature of the borderline personality disorder of the nation state: it’s here that its deepest fears are laid bare alongside its delusions of grandeur. (Saunders, 2016)

In The Global Visa Regime and the Political Technologies of the International Self: Borders, Bodies, Biopolitics, Salter (2006:168-170) argues that state sovereignty and border control are “inextricable”, as it is the state which has the power to both include and exclude. The border is a place of permanent exception, where you have no rights but at the same time are still subject to the law. Salter writes that it is the existence of international borders and the international visa regime that construct mobile bodies, and mobile populations. In general, one does not have the right to enter another country, it is instead a status to be requested. And this entry to the body politic, as it were, is “mediated through the administrative bodies of the sovereigns”, through the use of passports and visas. Indeed, with a tightening of travel in a world that is ever-more
connected, your passport may be what allows you to leave, but it’s the prized visa which permits entry.

The bordering process constituted by the decision to include/exclude is a dialogue between body and body politic requiring the confession of all manner of bodily, economic and social information. (ibid., 170)

Numerous documents are required by the state in order for them to make a decision regarding a visa application. Factors that are generally taken into account when sorting the acceptable from the inadmissible include financial status, suitability for the labour market, proof of acceptable behaviour, and that which forms the focus of this thesis – health status. These elements are used to testify to your character on your behalf, in the absence of your physical presence when the decision is being made (ibid., 176). Essentially, the state requires guarantees that you will not require assistance from them or threaten the safety of their citizens. With the advent of visas, control over the boundaries of the state has moved away from the physical borders of the land. This delocalization has led, in the case of mandatory health checks for visas, to the imposition of the border onto the terrain of the body instead.

Contemporary Biometrics

While this thesis topic cannot be reduced to a simple matter of biometrics, it is a related field of interest. In Taking People Apart: Digitised Dissection and the Body at the Border, Amoore and Hall (2009) examine the use of Backscatter x-ray technology to scan passengers at airports for safety and security purposes. The piece focuses on the notion of making the invisible visible, tracing the history of Renaissance and Enlightenment attempts to reveal what was then hidden and unknown in the realm of the body.

More relevant to my purposes is their discussion on the kinds of bodies these technologies produce. The body has become, in contemporary security efforts, “a territory to be mapped, a container for unknown motives and secrets, a canvas from which character can be discerned,” (ibid., 457). We desire to know, to visualize and to document the failings and the deviances of the body – that which makes it an unacceptable risk. Indeed, in Border Security as Late-Capitalist “Fix”, Chalfin (2002:291) describes biometrics as a practice which “seeks out the embodied markers of social pathology, construed as being situated within an individual yet threatening society as a whole”. Through this examination of the body, “It is made to speak at the same time as it is entirely disassociated from a knowing, self-conscious subject.”
Although writing in the field of terrorism and security, the concepts outlined in both articles are transferable to the context of health security as well. That is, the scrutinization of bodies and their subsequent classification into “degrees of risk, normality and deviance” (Amoore & Hall, 2009:460).

Linked to this idea of this bodily scrutiny is that of the invasion of privacy and the reduction of the body to an object of examination. Amoore and Hall argue that “The stripping, exposure and ‘writing’ of a body involves violence…but also a reduction of the person,” making reference to Agamben’s concept of bare life. This “reduction” of a person, by making them visible and documenting it, is closely linked to the desire to master, to humiliate, or make vulnerable (ibid., 452). By appealing to the individual’s right to privacy as a counterargument, we assume that the body is a sovereign territory that can be protected and secured. However, the authors argue that biometric advances blur the line between where the bodily borders begin and end:

If the contestation of new border security techniques becomes a battle over the body’s territory, we suggest that there is profound uncertainty as to what the limits of that territory may be, how it is bounded and enclosed. (ibid.)

South African Nationalism and Xenophobia

An important part of the context as it relates to border control and state power is acknowledgement of South Africa’s xenophobia, which periodically erupts in horrifying acts of violence perpetrated against foreign nationals in the country. The most recent outbreaks occurred in 2008 and 2015, although discontent simmers under the surface and sporadic attacks still take place.

Crush and Tawodzera (2014:655) write that the idea of foreigners bringing disease and using up the country’s resources is one of the most pervasive stereotypes held by locals. This is echoed by Landau (2005:1120), who explains that there exist near-universal assumptions by the South African populace regarding the threat immigrants present to health – in particular, they are blamed for “bringing in” HIV/AIDS. Indeed, according to Palmary (2016:11), within the South African context, the cross-border migrant represents a body associated with “stigma.

11 “Bare life” refers to a biopolitical subject, that which is reduced from a citizen to a physical entity (body) without any rights by the sovereign power. (Agamben, 2006).
threat and disease”; a body that is “set at the margins of the nation state threatening to puncture its protective shield”.

In a 2006 survey conducted by the Southern African Migration Programme (SAMP), they found that of those South Africans surveyed:

- 61% would support the deportation of foreign nationals who test positive for HIV or have AIDS
- 60% want a policy of mandatory HIV testing of refugees
- 65% felt that all foreign nationals should be tested for HIV/AIDS
- 56% felt that someone with HIV/AIDS should be precluded from citizenship
- 50% felt that migrants who were legally in the country should enjoy the right to access social services (including health), 27% would extend this right to refugees and 13% to undocumented migrants
- 49% felt that migrants bring disease
- Two thirds thought that legal migrants should be able to access free antiretroviral therapy (ART), half thought refugees should be able to
- Nearly two thirds said that undocumented migrants should not be given ART and 43% felt that they should always be denied treatment

(Source: Crush, 2008)

These attitudes are not limited to a particular demographic group, but rather run the gamut of the population of South Africa. The statistics I selected illustrate that not only do people still associate migrants with disease, they also want to deny access to people with particular illnesses (namely HIV) and deny them treatment once they are in the country.

The attitudes towards HIV are particularly interesting, as they illustrate an anecdote when illness was mobilized to bar people from entering the country on health grounds. In October 1987, the Minister for Home Affairs at the time declared HIV and AIDS a disease that would render one a prohibited person in South Africa (HRW, 1998). This particular legislation gave immigration officers the power to compel someone to undergo a medical examination if they suspected that the individual in question was not in the country legally and could have the disease. The Minister was also granted powers that would allow him to deport non-citizens if he decided it was in the public interest (ibid.). Civil rights activists protested, citing the fact that it would contribute to increased stigmatization of the disease and drive it underground, making
efforts to treat it more difficult. They also argued that the move had a political motive, as it could be used to prevent exiles from returning home overseas after the ANC and other liberation organisations were unbanned (Fourie, 2006:89-90). The restrictions were ultimately dropped four years later, in October 1991.

Xenophobic sentiment is also repeated at the level of government – South Africa’s Health Minister Aaron Motsoaledi claimed in November 2018 that the country’s health system is overburdened by foreign nationals and made reference to the number of foreign babies being born in the country12 (Clifford & Hazvineyi, 2019). While the 2002 Immigration Act replaced what was the extremely xenophobic Apartheid-era Aliens Control Act and included the provision that the Act should ensure “xenophobia is prevented and countered both within Government and civil society”, it was amended in 2004, changing this requirement to the rather more toothless “xenophobia is prevented and countered” (Crush, 2008:40).

According to researchers in the field, immigrants are often scapegoated for the failings of an under-funded, understaffed healthcare system that are the result of bigger systemic problems (Clifford & Hazvineyi, 2019). One concluded that there seems to be a national discourse that encourages xenophobia, particularly when it comes to healthcare (ibid.,). Crush and Tawodzera (2014:655) have dubbed this ‘medical xenophobia’, describing the “negative attitudes and practices of health professionals and employees towards migrants and refugees based purely on their identity as non-South African,”. These xenophobic practices include denial of medical services to foreigners, longer waiting times, and charging the “foreigners fee” to those migrants who, by law, should be exempt (Landau, 2005:1124).

South Africa has one of the most liberal constitutions in the world, which is supposed to apply to all inhabitants within it, regardless of legal status. For those people who would rather not have foreigners accessing rights they feel should be the domain of citizens, it makes sense to then try prevent people from crossing the border in the first place. Vearey (2018:6) argues that this xenophobia has health ramifications on both a national and global scale. It drives “uninformed, non-evidence based and potentially dangerous international (im)migration policy discussions and processes that may pose a threat to global health,”. Increasing health securitization and restrictive immigration policies can reinforce the association between foreigners and disease, thus perpetuating the xenophobic cycle of fear and violence. People could also be driven to irregular means of border crossing to avoid any potential health checks.

12 Unlike the US, South Africa does not grant automatic citizenship rights if you are born in the country.
Methodology

In this section, I will describe what kind of material was collected as part of the research, and how it was obtained. I will also provide an in-depth look at my chosen method of analysis, and how it was implemented. Finally, this chapter will also cover the limitations and ethical considerations involved in my research process.

Data collection

To reiterate, the overall aim of this thesis is to understand and explore the relationship between the body and the border by examining how the visa medical form is enacted. As a start, I thus searched for sources where the form had been publicly debated, i.e. policy debates, major media sources, NGOs, etc. What I found from this initial research however was that the form is surrounded by a general silence and it has seemingly not been the topic of any public debate.

What I did find were some online forums where visa applicants were discussing the form. I also had the medical form, and the surrounding legal framework, which, of course, made up an important site to examine further in order to meet my aims. In addition to the legal documents, and the views of applicants, I decided to collect additional data by using interviews with key persons who engage with this form in different capacities and at different stages in the visa application process. The choice fell on practicing lawyers and practicing doctors. Following the medical form as an “object” that travels through different sites (Bowker & Star, 2010:16), my method is thus a form of multi-sited research (Marcus 1995) where I trace the journey of the medical form and the stops it makes on its way – at the applicant, the lawyer and the doctor.

In terms of research methods, while this thesis utilizes a fully qualitative approach, I thus “mixed” up my methods in terms of using different material sources and obtaining this information in different ways in order to gain as full an analysis as possible. Below I will describe my approach in more detail.

Legal Documents and the Medical Form

The medical form formed the primary material of this thesis – not only do I analyse how the form travels, but also the specifics of the form itself, such as the wording, the categorisations and the choice of diagnoses, for instance. And since the form is derived from the 2014 Immigration Regulations, which in turn are derived from both the 2002 Immigration Act and
the 1974 International Health Regulations Act, I chose to make these pieces of legislature a key site of analysis in combination with the form. Secondly, one of the lawyers I interviewed emphasized the importance of looking at the preamble of the Act in particular. They explained that the preamble provides important explanations for the intention, purpose and reasoning for what is set out in the Act. This is then a valuable source of material when it comes to analyzing potential state motives around immigration, border control and health requirements.

Public Forums

Public forums with comments from people who had submitted medical forms as part of their visa application formed the second key site in this research process. Forums are a genre of website that provide a space for “an online exchange of information between people about a particular topic” (PC Mag 2019), usually involving questions and answers. During the research stage, I discovered several public-facing forums based around immigration to South Africa. On certain topic threads, people had asked questions about what was involved in the process of completing the medical certificate, and others shared their experiences.

The forum posts provided interesting comments and valuable insights to act as the third site in my analysis – the perspective of people who had actually undergone the process of having a medical form completed. These forums provided multiple perspectives instead of that which would be obtained from just interviewing one person. They also represent another important dynamic to examine when considering the tensions on the spectrum between what is required and what is actually done with regards to the form.

In total, I chose to make use five particular threads from four different websites. These particular threads contained specific information around the visa medical checks for South Africa, making them a useful resource. Going by the date of the first post in the thread, the oldest dated back to 2008 and the most recent to 2016. The length of the posts and threads varied – some kind only a few sentences, and others had lengthy paragraphs of information. Examples of the kind of content include questions around what the reports consist of, how and where to get them filled in, what tests are involved and how strict Home Affairs is regarding the completion of the forms. Other people then responded to these questions in turn, often giving feedback on their own experiences.

As mentioned, these forums are public-facing, so ethical considerations are minimal compared to if the information had been disclosed in a private group. Furthermore, there is no way to identify the members of the forum by their screennames.
As this thesis focuses on the construction and classification of migrant bodies wishing to enter the country, lawyers and doctors based in South Africa were ultimately the two “types” of professionals interviewed for the research. There were several reasons for this. Firstly, lawyers, specifically immigration lawyers, have a thorough working knowledge of South Africa’s immigration laws, and were able to provide insights into existing case law and how medical factors could come into play in the legal context. They were also able to address some of the gaps discovered during the preliminary research process, and reduce complex legal quandaries into layman’s terms. Doctors, meanwhile, were important figures to include since they are the ones who are authorized to complete the medical forms. They did not necessarily have to have encountered the form before – the fact that this is potentially something that they would be expected to complete as part of their daily practice was sufficient. They also provided a contrasting medical perspective to what is very much a bureaucratic discussion, particularly significant when it comes to justifications for particular processes, or lack thereof.

Furthermore, both the figure of the immigration lawyer and the doctor act as gatekeepers in this process of proving one’s health in order to access the country – a journey of the body, if you will, with different stops along the way. Consequently, it is both interesting and vital to obtain their viewpoints – two entirely different sites, legal and medical, that to all intents and purposes, do not seem to “speak” to each other, accounting for the multiple discrepancies highlighted previously.

In terms of sampling criteria for potential interviewees, they were required to be practicing doctors and lawyers in South Africa. Two approaches were utilized in order to recruit participants. The first was a form of snowball sampling – reaching out first to a small group of individuals who can then refer on others who would be relevant and possibly able to assist with the research question (Bryman, 2012:424). With this method, the first group of people approached are usually also research participants who then recommend others, but in this particular instance, the people first approached were simply those in my personal network who then went on to refer their contacts who were doctors or lawyers. Snowball sampling is an incredibly useful method when one needs to approach hard-to-reach groups – while doctors and lawyers are not rare in society, their workload and limited time means that they can be difficult to reach through a cold approach (ibid.). Indeed, snowball sampling allowed me to capitalize on the personal relations of people in their interconnected and overlapping social networks (ibid.). An initial introductory email was sent to the research participants once positive
responses had been obtained via my initial contacts. This email introduced myself and my research topic and explained what the interview would entail. The mandatory information letter containing more details about the research topic, ethics, and data storage was also attached.

The second method used to obtain participants was through generic purposive sampling, that is, selecting individuals who met a specific criterion (Brydon, 2012:428). In this case, the individuals occupied professional positions that were relevant to my research – doctors and lawyers. In order to do this, I compiled a list of South African law firms with an immigration department and healthcare centres that offered visa medicals. I then sent out a preliminary email directly to the lawyer/doctor when the contact email was provided, or to the general information address if no specifics were provided. The email contained a request for an interview, detailing my research topic and what kind of information I was interested in obtaining from them. The aforementioned information letter was also attached. Follow-up emails were then sent a week later, and finally phone calls were made directly to the firm/centre to confirm research participants.

Aware of their workloads, I made sure that participants were able to set an interview time that suited their schedule. In addition, they were sent the medical certificate that is being problematized as part of the research ahead of time so that they could familiarize themselves with it in case they hadn’t seen it before. Interviews were conducted either face-to-face or via video-call, for practical purposes relating to the participants’ and interviewer’s location. The lawyers both worked at fairly high-end firms, one only offering immigration services and the other providing a range of legal services. The doctors were all general practitioners working in government hospitals, but with varying levels of experience. Some were fairly recent graduates, while others had spent several years working in public or private practice.

The interviews were qualitative, following a semi-structured format - ideal for times one is looking for the interviewee’s motivations, thoughts and opinions. This was facilitated through the use of largely open-ended questions. They make room for interesting or unusual responses that may point the researcher towards other possibilities they might not have considered and provide the participants with opportunities to embellish and add additional insights as they saw fit (Bryman, 2012:247). The semi-structured nature of the interviews was also a good fit as I required answers to some specific questions, but also had the flexibility to ask follow-up questions as I saw fit – especially when the interviewees made interesting or provoking comments (ibid., 212). It also permits the researcher to vary the sequence of questions, which is indeed what happened. Oftentimes, the interviewees picked up on the
direction I was heading or noticed the same discrepancies I had, and then went on to answer subsequent questions on the list before I needed to ask them.

Separate sets of questions were drawn up – one set for the lawyers, the other for the doctors. Both sets of questions focused largely on their actual respective practices, with the minutia of the particular process they would deal with and progressing to broader questions around their thoughts on what had been discussed and the medical testing of migrants. The actual medical form was used as an entry point to begin the interviews – have you encountered this form before? Does it come up as relevant in cases you represent? Or: have you met patients who need this form completed?

The questions then diverged according to profession. For the lawyers, the interview questions then progressed to hypothetical instances of how they would deal with a case of someone denied entry to the country on medical grounds, the intricacies of Home Affairs bureaucracy, the links between the law and the proscribed mental illnesses on the form, and their thoughts on the discrepancies revealed between the legal and medical realities. For the doctors, meanwhile, the interviews went on to question what they would do in order to complete the form, how they would define vague terms on the form such as “good state of health”, whether they saw medical justifications for screening and/or excluding people, the issue of listing mental illnesses, where doctor-patient confidentiality would fit in, and then, like the lawyers, their thoughts on the overall process and the tensions that occur between the legal and medical sites.

In total, six interviews were conducted, two lawyers and four doctors. They ran from between 20 – 67 minutes and provided a rich body of material for analysis. The research topic appeared to pique the respondents’ interest, which provided an immediate ease of access. The interviews progressed smoothly, in part thanks to the semi-structured nature which meant that we could pursue a more natural flow of conversation and follow certain anecdotes or topics of tangential interest, before returning back to the questions at hand. In terms of noticeable differences, the lawyers certainly elaborated more, which could be attributed to their profession – they had to refer back to the law, step-by-step, and then explain it in terms that would make sense to someone outside of the profession (i.e. myself). The doctors tended to be more to the point, perhaps due to their professional training, or perhaps due to the fact that there was less room for nuance or theoretical debate in terms of the majority of their questions – a definition, a biological justification, a procedure.

The full list of questions can be found in Appendices D and E
Data Analysis

Qualitative Content Analysis

In terms of data analysis, this thesis made use of a qualitative content analysis method. Essentially, content analysis involves examining the data for some kind of recurring instance - words, phrases or larger meanings (Wilkinson 2010:170). These instances are then identified and then grouped together via some kind of coding system. The coding system is usually developed from the primary unit of analysis, whether interview transcripts or newspaper reports, for example (ibid.). Grouping can be done based on the specific meaning of the words, i.e. synonyms, or based on their broader connotations and inferred meanings (Weber, 1990:12). These words, phrases or meanings that repeat will then inform the formation of different themes, discourses and patterns which occur in the written material (Wilkinson, 2010: 171). To put it more simply: “A central idea in content analysis is that the many words of the text are classified into much fewer content categories,” (Weber, 1990:12).

More specifically, qualitative content analysis differs from quantitative content analysis in that the former records the words in which the particular recurring “thing” or instance is mentioned or couched, while the latter simply notes the frequency in which they occur (Wilkinson, 2010:171). As such, the analysis can be presented in the form of quotations, rather than in tabular or numerical form. (ibid.). Once categories have been coded and identified, the researcher attempts to draw meaning from these findings in relation to the initial research question. Focus is on the actual wording used, although broader themes can also be drawn from the analysis.

This particular method has several benefits. Firstly, data collection via interviews with open-ended questions generates a huge amount of text when it is transcribed. Qualitative content analysis provides a way to condense this information into smaller, more useful units for analysis. Secondly, it is a very flexible approach, and can be applied to a wide variety of different media – in this instance, interview transcripts, forum posts and legal documents (Bryman, 2012:289). Interestingly enough, qualitative content analysis appears to be a popular and useful method for those conducting research in the health field (Hseih & Shannon, 2005:1278).

In the case of my thesis, the primary units of analysis were the form and the surrounding legal documents; the interview transcripts; and specific forum posts. The theoretical lenses outlined in the next chapter provided me with useful tools which informed how I read, examined
and sorted the textual data. When the interviews had been transcribed, I began to read through the data and pick out repetitive words, phrases and overall concepts. Once these had been located, I systematically sorted through the information again to locate synonyms and sentences with similar meanings to the initial keywords or ideas I had identified. Finally, these groups of words and phrases were then sorted into larger thematic categories, which I attempted to interpret and explain – keeping in mind the theoretical concepts and contextual information I have previously outlined.

Note: Within my analysis, I included quotes from the various sources. I indicated only the profession or category that they came from, for example, “doctor”, “lawyer” or “visa applicant”. This was done to protect anonymity of the respondents.

Ethical Considerations

Prior to the interviews, participants were first provided with an information letter that outlined the thesis topic, research ethics, data collection and data storage, and contained the contact details of my thesis supervisor. As a researcher at a Swedish university, I am required to follow the Swedish Research Council’s regulations for conducting ethical research – that is, principles for good practice which protect the integrity of the participants. These include reliability, honesty, respect and accountability, in line with the The European Code of Conduct for Research Integrity (Swedish Research Council, 2019).

Interviewees were required to consent to the recording of the interviews so that transcription could take place afterwards. For the face-to-face conversations I used a voice recorder, while for the video-call, I made use of the recent inbuilt recording function on the application. It allows for video and voice recording that automatically notifies the participants in the conversation that they are being recorded, and is available for download for thirty days in the chat log. The data has been stored safely and privately for the time it took to transcribe, after which it will be deleted.

The information letter also stated that the interviewee had the right to refrain from answering certain questions, request information to be removed or to cancel the interview. Participants were also alerted to the fact that during transcription, names and places would be anonymized for further protection, and that the data would only be available to myself. As professionals, the doctors and lawyers I interviewed are also in a much less vulnerable and precarious position than, say, an undocumented migrant. They were not being interviewed for
their life story, for instance, but rather speaking in their professional capacity, even when providing opinions or personal anecdotes. As such, the risk of harm to them as a result of what was disclosed in the interviews is minimal.

Limitations

Possible limitations for this thesis include the fact that there are other important sites of interest which were not included in the research process due to difficulty of access and the restrictions of a master’s thesis. These sites include the Department of Home Affairs and South African High Commissions (embassies) who also play a part in determining who qualifies for a visa and who does not – the former determining the specific regulations that applicants must follow.

Theoretical Framework

This chapter will discuss the theoretical framework informing my analysis. I make use of several disparate yet complementary theories with which to unpack my findings: one relating to the practical politics of classification in relation to how bodies are deemed to be in a state of good health, and another relating to the idea of citizenship and security: who is a “safe” body to allow into our society? This then leads to the theory of health securitization, that is, how the body and the border are enacted together, and how health concerns are often used as a cover for stricter border control.

Politics of Classification

This particular theoretical section is based largely on the book *Sorting Things Out: Classification and Its Consequences* by Geoffrey C. Bowker and Susan Leigh Star. They argue that the way in which we establish categories and standards, and subsequently determine who or what will be visible or invisible within this system, is in itself a political act.

But taking a step back - firstly, what does it mean to classify? Bowker and Star (2010:10) explain that a classification system is “a set of boxes (metaphorical or literal) into which things can be put to then do some kind of work – bureaucratic or knowledge production”. Ideally, classification systems will contain the following three elements: consistent, unique classificatory principles in operation; mutually exclusive categories; and total coverage of the world it seeks to classify, i.e. the system is complete (ibid.). However, in reality, no real-world working classification system ever fits these requirements perfectly.
Classification systems reflect ordinary biases in action – somebody, in the past, had to make decisions about who or what is legitimated, and how (ibid., 44). The spread, enforcement and maintenance of these categories involves negotiation and often force. Systems of classification have become so ingrained in our everyday lives that they are taken for granted, and thought is seldom given to how they came to be in the first place. Indeed, Bowker and Star (2000:46-47) write:

Whatever appears universal or indeed standard is the result of negotiations, organizational processes and conflict. How do these negotiations take place? Who determines the final outcome in preparing a formal classification? [...] Whose voice will determine the outcome is sometimes an exercise of pure power... Once a system is in place, the practical politics of these decisions are often forgotten...

It is impossible for one classification system to neatly organize reality for everyone: Bowker and Star (2000:239) explain that “apparently precise, measurable qualities often prove much fuzzier when looked at closely”. As such, there are multiple tensions embedded and embodied within the system, along with a particular set of values, policies, and modes of practice. Classification systems incorporate disparate viewpoints – but as there are multiple voices, so too are there multiple silences. There can also, however, be both advantages and disadvantages to being visible or unseen and unheard within a particular classification system. Furthermore, there are practical, political and often economic consequences resulting from the particular method of classifying.

In essence, classification systems serve to construct new divisions or reinforce existing differences: a category can be non-existent until we suddenly make it so. Essentially, “difference is the prime negotiated entity in the construction of a classification system,” (ibid., 231). At the same time, the thinking behind the implementation of a classification system is that of universality, or at least moving towards it. This is done by making certain elements comparable, so that everyone or everything is able to fit into their allotted place. As such, classification systems often form an integral part of modern state bureaucracy, an essential tool for organizing, although they can also be considered a historical artefact.

Classification systems can be used in a range of different contexts, as their purpose is to present knowledge in the form of transportable data that can be used by various actors. In this way, they can link thousands of disparate settings across both space and time. In the case of this thesis, we are dealing with a classification system specifically embedded within the
context of health and migration – determining what constitutes an acceptable standard of health in order to enter South Africa. There are multiple issues that become evident straight away – some of which will be discussed here, and some further on in the analysis section.

The Boundary Object

Related to the idea of classification is that of the boundary object. This is an object that arises out of the system of classification that allows for cooperation across different social worlds (Bowker & Star, 2000:292).

Boundary objects are those objects that both inhabit several communities of practice and satisfy the informational requirements of each one. Boundary objects are thus both plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. (ibid., 297)

In the case of this thesis, the boundary object would be the medical form. While boundary objects are intended to bridge the gap between different sites and interpretations, in this context, they can perhaps also be used to highlight the tensions that exist between the various sites. The medical form travels across different sites and through the hands of different practitioners – the doctor, the lawyer, the immigration official, the policy maker. It connects these disparate communities and allows for co-operation between them for the single process of someone applying for a visa. The boundary object itself is a stable thing, but it has different ontologies in different settings, and is thus enacted differently. The form here essentially shapes how these sites speak to each other, yet at the same time can be interpreted entirely differently by each actor. It can represent a different type of knowledge to each person, but is, however, still exactly the same piece of paper, used to sort people in relation to border politics.

Border Theory and Citizenship

In terms of deciding who to allow entry into a country, and who constitutes an acceptable body, Bridget Anderson’s concept of what she refers to as a “community of value” is of great use here. She explains that this metaphorical community is populated by a number of imagined characters – good citizens, failed citizens, tolerated citizens and non-citizens, to name but a few. The “good citizens” are those who share common values, work hard, obey the law and generally exhibit model behaviour (Anderson, 2013:3). Modern states attempt to present
themselves as a unified community, bound by these shared beliefs and practices, rather than just a collection of people situated under the umbrella of a particular set of laws (ibid., 3.) This idealized state of affairs thus needs protection from outsiders, those who would threaten the homogeneity, good character and moral superiority of this community (ibid., 2013:4). Indeed, Anderson (2013:4) writes that “The community of value is one of the ways states claim legitimacy, and in this way it often overlaps with ideas of the nation”.

A fundamental part of the visa process therefore is the state’s ability to exert control and decide who is permitted entry into the country. As previously mentioned, visas are a way to delocalize border control away from the physical border, and allow the state to pre-screen travellers before their arrival in person (Salter, 2006:172). While the visa process may be a fairly disembodied one, the body itself has become a carrier of the border, as well as its limitations and dichotomies (Lagios et al., 2018:53). It has become of central importance to the government, and to border control. More specifically, it is the immigrant body that bears the brunt of this focus. And not only is the border inscribed onto the body, the body also contains the particular distinctive features that will either led to its inclusion or exclusion (ibid., 59).

The nation has often been described in terms of a body, that is, a healthy body used as a metaphor for a healthy nation. Outsiders, therefore, represent a pathogen or a potential threat: “New residents, like new ideas, can provoke a defensive response metaphorically akin to the physical body’s immune reaction,” (Fine & Ellis, 2010:79). The threat represented by immigrants can be anything considered deviant or different from the set way of being promoted by the community of value - from religious practices to modes of dress or diet. But this idea of the foreigner as an “infection” or “pathogen” is also used very much in its literal biological meaning. And this fear of diseased immigrants and sick bodies:

[…] echo[es] dramatically with cultural images of the nation as a body that is subject to disease. According to this long-held metaphor, not only do individuals become ill, but so do nations. (ibid.)

The medical form I am problematizing in this thesis is used for long-term visas, for stays over three months. In this way, we can say that it targets those who become “semi-citizens”. Applying Anderson’s theory then, one can reason that when it comes to state security and the safety of its people and its values, the state wishes to accept those people who emulate the principles of the good citizens and do not represent a danger to society. More specifically, in
the context in which I am writing, “good citizens” are those with “safe” bodies who do not pose a health risk to the local population. According to Lagios et al (2018:54):

[…] new forms of citizenship and new modes of subjectivity are now emerging in reference to the body itself; the ethical, prudential, respectable citizen is now the healthy, self-disciplined, self-governing subject.

Good citizens, in Andersons’s metaphor, can be considered analogous with what Briggs and Mantini-Briggs (2004) refer to as “sanitary citizens”:

We introduce the term sanitary citizens in drawing attention to the way that some people are credited with understanding modern medical concepts and behaving in ways that make them less susceptible to disease. Others get branded as unsanitary subjects; they are deemed to be incapable of helping themselves or taking advantage of medical services—and even presented as threats to the health of the body politic.

Sanitary citizens, good citizens, thus embrace lifestyle habits which will (supposedly) keep them healthy and reduce their disease risk profile – a valued member of the community. Indeed, the notion of risk “is constitutive of the dominant medical discourse” (Lagios et al, 2018:56). This in turn leads to the “control, marginalization and exclusion” of certain vulnerable groups of migrants who are viewed as a threat to the public, and subsequently endure infringements on their freedom, such as monitoring, detention or deportation (ibid.). And when it comes to medical examinations and other bodily-related security checks, Amoore and Hall (2009:454) write that they “bear a striking similarity to previous attempts to locate deviance in bodies”.

The state’s control over the movement of bodies and the management thereof relates to Foucauldian notions of biopolitics, where bodies are subject to discipline and regulation by state apparatus (Lagios, 2013:53). This power over the body occurs on two levels: the first with regards to the mobility of the body (or a population of bodies) across a border, and the second in relation to the actual health conditions of an individual body. And while the state may attempt to regulate bodies, these bodies in turn regulate themselves in relation to what is required to cross a border. Biopolitics thus serves to sort (migrant) bodies into those deemed “normal” and those categorized as “pathological” (Lagios, 2018:56). As shown in the research context chapter, migrant bodies have long been associated with disease, and are still pathologized as “as a disease-carrying threat to the nation state,” (Harper & Raman, 2008:5).
Ultimately, the combination of state legislation, public opinion, changing ideas of citizenship and narratives of disease serve to create what Zylinska (2004:525) refers to as “an ethics of bodies that matter”. And with the construction of bodies that are valued, it stands to reason that at the same time, this also creates bodies that do not matter. Whose bodies count, who is entitled to protection, and who deserves treatment are often determined by the dominant immigration discourse.

**Health Securitization**

The concept of health securitization is derived from the theory of securitization, put forward by scholars from the Copenhagen School of thought. This initial theory outlines the process by something becomes identified and acted upon as a threat, i.e. securitized (Yuk-Ping & Thomas, 2010:448). This theory was then applied specifically to a branch of human security – that of health. Even the language of health and disease has been used metaphorically to describe security threats – from terrorist “cells” to their “infection” of society and the need for “eradication” (Fairchild, 2004:535).

Health securitization refers to measures put in place, through the power of the state, with the aim of protecting public health in a global or national context. It straddles two competing agendas – that of global public health, and the other of state sovereignty and security (Vearey 2018:7). The problem lies in the fact that the lines between the two become blurred, with health securitization efforts often moving away from a focus on protecting health and into the realm of foreign policy (ibid., 2018:9). In other words, while health challenges may be identified as threats to state security, the weighted considerations are far from medical (Yuk-Ping & Thomas, 2010:447). Responses to health threats can end up taking into account the domestic and international political situation, as well as economic objectives and social or cultural norms.

The need for the free movement of people (as well as goods and capital) in an ever-connected, globalized world creates tensions with the state’s desire to regulate the movement of people. As such, the idea of the immigrant that brings germs is largely a cover for what Harper and Raman (2008:22) term “wider anxieties about the disintegration of the social order”. Indeed, when immigration is viewed as a threat to national security, the dominant rhetoric around the issue of is often articulated in medical terms. The xenophobic myth of the diseased foreigner and the associated moral panics around illnesses such as HIV are often used to inform foreign policy and national security measures (Vearey, 2018:7-10). Indeed:
The prevailing fear and threat of the diseased foreign body as an unknown outsider whose movements should be restricted in order to exercise sovereignty and ‘protect’ a native population are applied across both global health security and national security agendas. (ibid., 19)

Harper and Raman (2008:8) argue that health threats are being used in both the reconstruction of borders as well as the reimagining of what constitutes a “rightful citizenship”. Migration has essentially been medicalized: it has been displaced from the realm of politics and instead rearticulated as a depoliticized, technocratic matter (ibid., 56). The fear of open borders has been articulated instead as a public health crisis. Furthermore, while the idea of disease has been deterrioralized; i.e. it does not respect borders and can travel freely, the body in turn has become reterritorialized, and national borders have become “medically patrolled” (ibid., 8).

This in turn means that legitimate health concerns can be co-opted and used by states to justify the tightening of borders, the restriction of movement and the deportation of non-nationals under the guise of protecting public health. The preoccupation with state sovereignty is perhaps epitomized in the struggles over the control one’s borders, determining who may be granted access to live amongst its people and take advantage of its resources. However, the tightening of borders under the guise of protecting public health can ultimately be counterproductive to this goal, as increasing securitization has several negative effects on the health of mobile people.

For example, people may resort to irregular means of border crossing to avoid the mandatory health checks. Since health status has been used in many instances to deport undocumented migrants or deny asylum seekers entry, ill migrants are reluctant to seek treatment for fear of arrest and deportation. When they eventually reach the point where they have to get medical help, they are in a much worse state than if they had just gone when they first experienced symptoms. Excluding entry based on certain conditions also leads to the stigmatization of people who are suffering from the disease in question. This makes them less likely to report their symptoms and receive treatment. Increased border security also has negative effects for cross-border healthcare schemes, particularly for illnesses such as TB or HIV that require a strict treatment regimen (Vearey, 2018: 9-11, 13). All this culminates in an environment that ultimately facilitates the spread of disease and increased burden on the public health system.
In my next chapter, where I turn to the analysis, I will thus explore the politics of classification embedded in the medical form itself and in the ways it is being discussed and put into practice. I will further explore the discourses produced in these contexts through the light of abovementioned perspectives of border theory, citizenship and health securitization.

Analysis

The aim of this analysis is to try to answer the research questions put forward in the beginning of this thesis:

- How is the medical form actually used in the South African context?
- How are different actors (medical, legal, personal) reasoning around this specific template?
- What kind of issues arise through the form’s use? What does it do?
- What kind of bodies are constructed through the use of the form?
- How are the body and the border enacted together?

Troubling Terminology

To reiterate, the medical form is governed by the South African Immigration Act of 2002, which states that people infected with certain prescribed diseases are considered prohibited persons. The Immigration Regulations of 2014, derived from the Immigration Act, explain where this list of diseases can be found: South Africa’s International Health Regulations Act of 1974. (Not to be confused with the WHO regulations of the same name.) These prescribed diseases in the act are cholera, plague, smallpox and yellow fever. The South African Department of Health also has the authority to list certain diseases as rendering a person non grata from time to time (DHA 2016b).

This medical form contains several terms that can be considered vague, insensitive and even discriminatory. The form requires doctors to confirm that they do not find you “physically defective” in any way. However, there is no definition provided as to what this term actually constitutes. Furthermore, the doctors I interviewed confirmed that they do not receive any training with regards to this form in medical school, nor does there appear to be an official government guide for doctors who are required to complete the form. It then falls to each
doctor’s individual interpretation of what or who qualifies as “physically defective”. The same issues arise when it comes to defining “generally in a good state of health”.

The form also wants the doctor to conform that the applicant is not “mentally disordered”. Here they provide an indication of what they mean by this term, as there is a table at the bottom of the form listing the ICD-9 codes of the mental health conditions that the state considers to constitute “mentally disordered”. As seen in the table in the research context chapter, these codes cover a wide range of conditions ranging from anxiety to autism.

The provided list of codes concerning mental illness also mean that doctors can refer to official diagnostic systems, i.e. they do not have to rely only on their own professional opinion as in the cases of “physical defective” and “generally in a good state of health”. However, when subjected to closer scrutiny, classifications of ill-health are not as clear-cut as they seem to be. The ICD, for instance, was never intended to capture all medical conditions that exist; rather it is a “statistical classification system” and an “information-processing tool” to “permit the systemic recording, analysis, recording, interpretation and comparison” of epidemiological data (Bowker & Star, 2000:72-75, 123).

Epidemiology requires that diagnoses fit neatly into different categories that can be measured and compared. However, reality is different. Critics have argued that systems such as the ICD privileges the voice of the doctor over the voice of the patient – which is particularly problematic when it comes to diagnosing mental health disorders, as this is not something that can be scientifically tested via a scan or blood test, for instance. It is largely dependent on how the patient describes their symptoms, which can often be culturally specific, or not correspond with the prescribed indicators. Categorization systems of mental-ill health also single out what is different and what is considered normal (Bowker & Star, 2000:53; Bredström, 2017).

The ICD also provides medical practitioners and other related professions with a singular way to talk about complex, fluid phenomena (Bowker & Star, 2000:95). While the diagnostic codes may be static, disease exists on a spectrum. ICD codes do not take into account the overall physical condition of the patient, for instance, or their treatment history (ibid., 170). Two people with the same ICD code diagnosis could present very differently in terms of their fitness for travel and risk of contagion, for example.

Some people may have a condition which overlaps more than one category. Which one do medical practitioners choose to write on the form, and what implications does this have when it comes to evaluating the “fitness” of a person – for instance, when applying for insurance or a visa application? On the other hand, it is impossible for the ICD to capture the complexities of illness. It is largely focused on “regular patterns of recurrent” conditions, rather than rare
ones (ibid., 125). What does it mean then for someone if there is no category for their specific condition? At best, they would be assigned the closest matching category, but this would still misrepresent their medical reality. Ultimately, while diagnostic systems such as the ICD provide us with a way to coordinate discrepancies and sort people by means of categories, they also silence certain people or conditions.

There are additional queries regarding the codes that pertains to the medical visa form under scrutiny here. South Africa began using the new ICD-10 system in 2005 and proceeded to roll out the implementation in stages over the next several years across the various healthcare providers and medical insurance companies (Department of Health, 2014). However, as noted, the form still uses the old ICD-9 codes. There are significant differences between the new and old diagnostic system. The ICD-10 has greatly expanded the amount of codes available than its predecessor – from around 13,000 to approximately 68,000. This has also allowed room for much greater specificity: for example, whether the injury was on the right or the left arm, for instance. The new codes provide medical practitioners with the means to indicate anatomical location, etiology, severity, initial or subsequent encounter, and other relevant information (American Medical Association, 2014).

That South Africa is still using the old system on its forms points to both bureaucratic oversight, can make things more difficult for doctors who have to now navigate back and forth between two different diagnostic systems in their daily practice, and can also lead to specificity problems for the patient as described above. The difficulties and confusion are compounded by the fact that two of the code categories on the form do not even match up with the ICD-9 structure. Two of the code categories listed on the form “308 - Behavioural disturbance of childhood” and “310-315 - All forms of mental retardation” do not match up with the ICD-9 codes. According to ICD-9, there is no category for “Behavioural disturbance of childhood” - they have “Mental disorders diagnosed in childhood 312–316” and then “All forms of mental retardation - 317-319”.

Finally, the form requires the doctor to confirm that the patient is “not suffering from leprosy, trachoma, venereal disease, or other infections or contagious condition”. “Other infections or contagious condition” is another example of non-specific phrasing, because unless a patient is symptomatic, there is no way for doctors to identify or test for every possible infection that could be spread. There is also a disconnect between the diseases on mentioned on the form and the diseases listed in the 1974 International Health Regulations Act, which are cholera, plague, smallpox and yellow fever. This Act, barring a few words in the preamble, is exactly the same text as found in the WHO International Health Regulations that were published
in 1969 – which makes sense, as South Africa was signing these international recommendations into national law. But then why does the form not list these particular illnesses instead? Where did the requirement for leprosy, trachoma and venereal disease come from?

It is interesting to note that leprosy and trachoma fall into the category of “neglected tropical diseases” (WHO, 2019b). As the name suggests, these diseases are found in tropical and subtropical countries. They are considered “neglected” as they do not receive much global attention or research funding with regards to their treatment and eradication since they occur in low-income countries. Venereal diseases, meanwhile, have long been associated with poor morals and character (Brandt, 1987:5). While we cannot draw any definitive conclusions, the conditions on the form do seem to point to a particular kind of immigrant as unwanted or inappropriate – lower-income countries where leprosy and trachoma are more prevalent are connected with specific ethnicities. This consideration of which bodies are deemed worthy will be discussed later in the concluding chapter.

While there does seem to be a lack of information available around this form, as mentioned, the current medical form does bear a startling resemblance to the categories of ineligible aliens outlined in the US McCarran-Walter Act of 1952. This act, subsequently overturned in 1965, classified undesirable immigrants as those with people with epilepsy and other mental defects, drug addicts and alcoholics, those with leprosy or contagious diseases; those with a physical defect, disability or disease that would restrict their ability to earn a living (Markel & Stern, 2002:773). These categories appear almost word for word on the existing South African medical form. There appear to be commonalities, therefore, across countries when it comes to the kind of bodies they are willing to accept into their communities.

In summary, through the theoretical lens of Bowker and Star, we can see the first set of problems that arise from using this particular form to classify people in the both the bureaucratic and medical context. More specifically, using Anderson’s concepts of “good citizens” and “communities of value”, we can see how the form indicates the type of good citizen that the South African state appears to be amenable to accepting for long-term stays – those people lacking the various conditions listed on the document.

**The Form is but a Formality**

As it was the starting point for my investigation, it makes sense to begin this analysis with an examination of the medical form. However, what I thought would reveal discrimination and exclusion on health grounds actually turned out to be nothing of the sort. Instead, this medical
form appears to be nothing more than a tick box, one of many to be checked off on the long list of documents required when applying for a visa. At least, according to the lawyers I interviewed and applicants who have undergone the process.

_They are looking at particular documents that are entitled to your visa. So this is just – like a tick – documents. They don’t really pay attention as much – only, is it the original document or is it a copy? [Lawyer]_

Indeed, there is no existing case law indicating that anyone has ever been rejected for their visa application on the grounds of what was written on their medical form, and then gone on to challenge it in court. This, of course, does not mean that nobody has ever been denied on these grounds – just that it was never taken to court. But from the discussions with the lawyers, it seems highly unlikely. Significantly then, it appears that the form is not actually used as a way for the state to bar foreigners from entering the country – at least in terms of one’s health status.

The only important consideration seems to be the fact that the form cannot be more than six months old at the time of submission, it has to be the original, it needs to be completed by a registered medical practitioner, and must be completed in English or in one of the other official South African languages. These are purely administrative, rather than medical concerns. To the best of the lawyer’s knowledge, the medical reports that are submitted to the department are looked at by standard officials, rather than a medical specialist. They simply have to presume that the officials have received training on what constitutes an appropriate completion of all the documents necessary for a visa application.

Even in forum discussions regarding the required medical reports and what they entailed, one commenter emphasized: “Most importantly remember to use the correct forms…otherwise the whole exercise ends up being a waste of time.” The implication, of course, that they felt having the correct form was of a much greater concern than whatever would take place in the doctors’ rooms. Another discussant viewed the report as simply something “…you literally get your GP to sign…”.

In summary then, this medical report appears to be just another mandatory document on the list, a box to be checked, a form to be filed in the bureaucratic regime of the state. It is a required part of the visa application process, visible and yet not, significant yet overlooked and apparently never questioned by the multitudes of people who encounter it along the way.
Interpretations

While the form did not seem to be of much significance to any of the stakeholders involved, it is nevertheless a prerequisite for the visa in question. As such, it could also be mobilized by the authorities and possibly increase its importance. The blurriness of the form nevertheless opens up for a number of interpretations and in this section of the analysis will thus take a closer look at what the medical form reveals in terms of the “blurriness” or the vague, indistinct nature of how it works and what it says; the strategies used by doctors, lawyers and the applicants themselves when they encounter this document; the implications for the rights of the individual; and the issues surrounding perceived or actual threats to collective public health and society.

Blurred Lines

As mentioned, by “blurred lines” or “blurriness”, I am referring to the non-specific nature of the wording on the form, which leads to subjective interpretations, confusion and inconsistencies across the different sites where the form is enacted. It is not clear-cut, it uses outdated legislation, and generally opens up space for key personnel to read into it as they see fit.

Firstly, how do the applicants in the forums reason around the form? Most viewed it as just another piece of paper, and indeed, another hassle, as they had to find a place for x-rays to complete the accompanying form, and the appointment costs were often pricey. There was sometimes confusion, as some people did not know that there was an actual form to fill in, and they thought it meant that the doctor needed to write something out. However, there were varying responses to the content of the form. Some people were fairly unconcerned about it – one referenced it as a form “to say you’re not mental or have VD!” – but another forum respondent, for example, seemed very concerned if there would be an HIV test or not, and whether “failing” any of the tests would result in the cancellation of their visa. Those who had undergone the visa application process before also did not view the completion of the medical form as a big deal, based on their previous experiences: “Home Affairs is not really that strict regarding medicals…” and “I agree they are not fussy but it’s unpredictable so you are better on the safe side.”

Secondly, how would medical practitioners interpret this form? Looking at what “physically defective” could refer to led to the following responses from the interviewees:
I think it is quite insensitive and also very broad. What does physically defective mean? Is it because they lost a limb? Is it because their kidneys don’t work? [Doctor]

Physically defective in any way – I mean really, then you should record if they’ve got like a scratch or something. That’s very vague. [Doctor]

I don’t know what kind of deformities would not allow one into another country [...] If I’ve got a leg missing, how is that a problem in any way, shape or form? [Doctor]

I’d assume that meant to not have any physical impairments or deformities. So no functional loss and no birth defects or acquired traumatic amputations or something like that. [Doctor]

Meanwhile, when it came to defining “generally in a good state of health”, there were two schools of thought among those interviewed: one along the lines of ensuring that the applicant does not have a “dangerous transmittable disease” that could “harm our citizens”, and the other more focused on the everyday functioning of the individual – i.e. that whatever condition they may have is under control and being treated, and that they are able to get through a “normal day functioning well”. The medical interviewees concluded that the form used strange, vague language, with one bringing up an ethical issue of the potentially discriminatory wording. These two schools of thought indicate a key analytical point in this analysis: the tensions between individual rights (free from discrimination, right to medical treatment, right to dignity) and those of the wider community (right to protection from preventable disease and other harms). These tensions will be elaborated on later in this chapter. However, from this discussion, we can see that medical practitioners are left to use their own judgement and intuition to try, as one doctor explained, to answer the question that they think the form is asking.

On the other hand, lawyers seemed to view this form with less ambiguity - as simply another requirement on the list of documents required for a visa application.

 [...] these documents are more – like you know when you have a formula, and you say tick, tick, tick [...] [Lawyer]

So on one hand the form came up as relevant in their work in that it was a mandatory piece of paper in all the cases that they represented, but on the other hand, it never became anything
more than that. The contents of the form never became a point of relevance in and of itself – simply whether it was still valid. One lawyer took the stance of asking clients and doctors to disclose only the required information and nothing more, because they felt it was unnecessary and that the state was not entitled to know. They felt as long as they could show that the person was fit to travel to another country and would not harm anyone with a contagious condition, then it was sufficient. However, the ambiguity could sometimes be to the lawyers’ and clients’ advantage, as we will read about in the strategy section.

The law itself reveals another legislative discrepancy when it comes to the listing of mental health disorders on the form. Nowhere in the official Immigration Act or Immigration Regulations does it actually specify that a diagnosis of one of these specified conditions designates you as a “prohibited or undesirable person”. All that could possibly refer to mental illness is the mention of someone who is likely to become a public charge, i.e. dependent on government funds, or someone who has been declared judicially incompetent, i.e. lacks the mental capacity to participate in legal proceedings. This reveals how the form is disconnected from the legislation, screening for mental illness without a legal justification.

When investigating other countries’ reasoning around this, I found that the Australian Department of Home Affairs website (2019) listed “intellectual impairment” as one of the top five “conditions most commonly identified as affecting permanent visa applicants who have failed the health requirement”, due to the fact that they are likely to result in a significant cost for the state. The US, meanwhile, bars immigrants with a diagnosed mental disorder only if it is also associated with harmful behavior, defined as “behavior that may pose, or has posed, a threat to the property, safety, or welfare of the applicant or others” (USCIS, 2019). There does not appear to be any information in the South African context, however.

According to one of the lawyers I spoke to, there are quite a few inconsistencies across the spectrum of South African legislation. In her opinion, it either just hasn’t been picked up by anybody, or it has been noted but is very far down the list of priorities of things to rectify. More specifically, from my own research, the reason that South Africa is still using the outdated WHO International Health Regulations that were ratified in 1974 is another result of the slow turning wheels of bureaucracy (Gray & Vawda, 2016:4). An updated version of the International Health Regulations was actually drawn up in 2013, but it has never been tabled in parliament. Part of this can be attributed to the slow passing of legislation by the Health Department over the past few years – much of the focus seems to have been on the formation of the new National Health Insurance bill. Another reason the bill has not been tabled is that
some of the recommendations from the IHR have already been implemented through other bills and amendments, such as the transfer of Port Health services to national authorities (ibid.).

In summary, the form here represents Bowker & Star’s theoretical concept of the boundary object, as discussed in the previous chapter. While it is a singular object that travels to various actors and is intended to facilitate a particular purpose, it is interpreted very differently by doctors, lawyers and the applicants themselves. It also reveals multiple inconsistencies in terms of the law, which are highlighted through this very process of trying to classify acceptable, healthy bodies in this manner.

Bureaucracy and Prejudice

While the immigration lawyers may view the form with little ambiguity, the context in which they operate is anything but.

_It really is like the wild west. To practice law in this field is very challenging._ [Lawyer]

State power is exercised through the Department of Home Affairs, which acts as the decision-maker and the gatekeeper on the behalf of the South African government in their efforts to secure the border. Indeed, the preamble of the Immigration Act makes this specific, noting that this Act is to ensure that:

(b) security considerations are fully satisfied and the State retains control on the immigration of foreigners to the Republic;

However, the South African Department of Home Affairs is a notorious institution, striking fear into the hearts of locals and immigrants alike. There are multiple problems faced by both locals and immigrants when it comes to interacting with the DHA. These include the lack of clarity surrounding the requirements, long queues, offline systems, as well as fraud and corruption (which is better than it was but still very much a reality), lost documents, lengthy processing times, an inability to get in contact and overall mismanagement, inefficiency and lack of accountability. There have been a number of research articles written about immigrants’ encounters with this state institution which substantiate the above claims, from the illicit market for legal documents due to fruitless encounters with Home Affairs (Alfaro-Velcamp et al, 2017); the interactions of department officials with the public (Hoag, 2010); the experiences of
refugees, asylum seekers and non-profit organisations when attempting to liaise with Home Affairs (O’Brien & Reiss, 2016); the excessively long waiting times faced by migrants (Sutton et al, 2011); how state institutions such as the Home Affairs facilitate the criminalization of immigrants (Alfaro-Velcamp & Shaw, 2016); and the discriminatory treatment experienced by African immigrants at Home Affairs (Umezurike & Isike, 2013).

It is important to bear in mind that the workings of the Department of Home Affairs remain a mystery to the nation, according to the immigration lawyers interviewed, as well as the several research articles cited in the paragraph above. For instance:

[…] inconsistent and obtuse immigration policies have not only confused immigrants, the general public, government administrators, and lawyers, but have also normalized the population to ambiguity in laws that apply to foreign nationals. (Alfaro-Velcamp et al, 2017:217)

The bureaucratic machine is thus mired in secrecy, confusion and inconsistencies, and it is within this context that visa applicants are forced to negotiate their stay in the country, and in which immigration lawyers practice.

It is important to note that what the lawyers’ relayed in the interviews is not necessarily fact, but rather their own experiences from navigating this system. “Home Affairs Directives” or “Immigration Directives” (the terms appear to be used interchangeably) instruct Home Affairs on how to behave and makes decisions.

*I’ve never seen a directive that specifically says if you have this particular disease then you will not be allowed in the country. I’m sure something like that must exist. [Lawyer]*

According to one of the lawyers I spoke to, these directives are not available to the public or immigration practitioners. In an attempt to try and verify this statement, I did find a few directives listed online on various immigration sites (Work Permits South Africa, 2019; Integrate Immigration 2019; VFS Global 2019). Ironically enough, the search also revealed Immigration Directive No. 28 of 2015, which concerned transit visas, and concluded with “This Immigration Directive is confidential and for internal use only.” (DIRCO, 2015). Thus there appears to be much confusion around the matter. The directives do not seem to be neatly packaged and available for public perusal, and taking my interviewee’s comments into account, they are
inaccessible to at least certain practitioners. Furthermore, sometimes the directives do not even reach officials themselves, as illustrated by this anecdote:

[…] a Permitting official told me about how she learned of an important change in policy simply by chancing upon a DHA circular underneath a pile of papers […] The policy change had gone into effect weeks before the official found the circular, and she recalled turning away a number of applicants on account of asylum seeker status. (Hoag, 2010:9)

One lawyer explained that their main challenge is the discrepancy between how immigration lawyers feel the law should be interpreted, and how DHA officials feel it should be applied.

You don’t actually know exactly what is going on in the heads of the people that are actually going to be processing this. [Lawyer]

In the experiences of the lawyers, they found that decisions seem to be made on a case-by-case basis, without any kind of consistency. They claimed that things are very much dependent on the individual reasoning of the specific Home Affairs official who receives the case. With the administrative failings of Home Affairs as mentioned above, this is not always due to malicious practice, but rather the dysfunction of bureaucracy:

Many of those with whom I spoke reported that the DHA failed even to educate them on the Immigration Act of 2004, the primary legal document pertaining to their responsibilities. (Hoag, 2010:9).

However, one cannot dismiss South Africa’s context of xenophobia entirely. One would like to assume that DHA officials are leaving their own biases and prejudicial attitudes at the door, and making decisions based purely on what the law states. However, research has shown that this is not always true. Crush and Tawadzera (2014:656) argue that state officials, such as those at the South African DHA, “do not leave their hostile attitudes at home when they come to work”. O’Brien and Reiss (2016:3429) found that “Some of the officials at the Department of Home Affairs…were prejudicial in their practices towards asylum seekers/refugees” and Umezurike and Isike (2013:59) write that:
the crisis of poor service delivery to African immigrants is not necessarily an operational one faced solely by the department; it has more to do with how African immigrants are perceived and treated.

Hoag (2010:10) notes, however, that while prejudice does exist amongst Home Affairs officials, it does not necessarily always lead to discrimination. In other words, one cannot assume that every denied application is the result of xenophobia, but at the same time, it is a factor that cannot be entirely dismissed.

This entire discussion around reasoning and the decisions made in terms of visa applications epitomizes what Salter (2004:182) writes about when he mentions the ways that “governmental bureaucracies enact specific roles within an administrative structure, so that we may not infer practice from policy documents alone”. In the South African context, what is written down on paper in the form of laws and policies does not resemble the reality; moreover people such as immigration practitioners cannot make what could be considered reasonable assumptions from the government documents they have access to.

 [...] sometimes you have decisions that make sense and others you just don’t even know what they’re trying to say to you...[Lawyer]

According to one of the lawyers, when a decision comes back to the lawyer and applicant, oftentimes they do not know whether the decision was made because the case worker was having a bad day, or whether they genuinely pursued the wrong course of action with regards to the visa application. In his research article about South African immigration bureaucracy, Hoag (2010:9) notes that apart from the administrative issues,

 [...] officials also act inconsistently for reasons more within their control. Mood and other physio-emotional issues can be factors, as can insidious ones such as racism, sexism, or xenophobia.

Nothing, as one interviewee told me, is concrete. That is, until it goes to court. For this reason, they reasoned that Home Affairs tends to avoid court cases so that nobody knows what the position is. And the way they supposedly do this?
[...] if you are suing Home Affairs for the outcome of a visa, a temporary visa application which should have come out six months ago, then you’ll get your outcome the day before court. So you actually won’t have any rights to be there. [Lawyer]

To understand the above anecdote, one needs knowledge of the excessively long waiting times experienced by some applicants – from one to two years, in some cases. Migrants attempting to follow the proper channels to obtain documentation that legitimizes their stay in the country are ultimately punished by pursuing this route.

In summary, this analytical section showcases how gatekeepers such as Home Affairs officials operate against the background of a fairly prejudicial national context, complicated by bureaucratic and administrative failings. These are the very people who exercise power on behalf of the state, determining and classifying who ultimately “passes” as a good citizen permitted access to Anderson’s theoretical concept of the “community of value”.

Strategies

Above we examined how key sites reason around the form. Now what kind of action do they take in regard to it? What kind of strategies are pursued in the completion or use of this particular document?

Due to the nature of the form, it seemed to be an arbitrary affair. When I questioned how the medical practitioners would go about completing the form, the responses differed. In terms of the “physically defective” aspect, one said they’d err on the side of caution and write down anything that they found that was abnormal at all. Another said they would take a more visual approach, seeing whether the patient could use all their limb and noting down any obvious disabilities. They mentioned perhaps giving them a few physical assessments to see how mobile the person is, and whether they could complete the so-called “normal activities of living”.

When it came to confirming that the patient did not have any of the listed diseases, all said they would ask about medical conditions and do a general check of vitals and systems such as cardiovascular and abdominal, but differed in how invasive or in-depth they would be. For example, one interpreted the form to mean they would have to do a gynaecological examination, and the other said they would simply ask the patient if they had any symptoms and take them at their word.

Mental health, as mentioned, is not something that can be diagnosed through any kind of blood test or scan. Unless they are the applicant’s regular doctor, there is no way for them to
know if the patient actually has been diagnosed with any of the listed conditions – it is based entirely on the applicant’s willingness to disclose their condition. As one informant explained, the only thing doctors can do is rule out any active psychotic conditions by asking a prescribed list of questions designed to assess the patient’s mental state. They could possibly rule out certain disorders, but cannot make a definitive statement.

The doctors also had to work with the disparity between rich people and poor people, specifically when it comes to the completion of the medical form. Indirectly, through the mechanisms involved in the visa application, the process naturally favours those with privilege.

*These people are trying to enter the country for a shot at making a decent living. And maybe the R30014 consultation that they’re paying you is a massive hit […] I don’t think it’s appropriate to put someone through the financial burden. [Doctor]*

*If you’ve got someone who’s scraping together money to try and get a visa…you might try and cut costs as far as possible…If it’s a wealthy person you could try and do things as thoroughly as possible to try and avoid them being rejected. [Doctor]*

As explained in the public health section of the previous research chapter, people generally have to pay for doctor’s appointments, albeit on a sliding scale according to their means. Depending on the waiting times and the availability of services in the area, some people may even be forced to go to a private practitioner if they are pressed for time. A R300 consultation like the doctor mentioned in the above quote can be a substantial amount of money for many economically marginalized people. Apart from the financial status of the patient, one of the doctors admitted that it would also depend on how much time they had that day, which would in turn determine how thorough they were in conducting tests to complete the form.

The doctors I interviewed also appeared distinctly uncomfortable with their role as gatekeepers. What they write down on the form can be theoretically used to influence a decision with regards to their visa decision. They have a duty to disclose what they find, but at the same time, there were several ethical issues brought up: the vague and subjective language, the issue of doctor-patient confidentiality, and the fact that they would have a role to play in potentially barring someone entry from the country.

*But I don’t think as doctors we’re in any position to make those calls. [Doctor]*

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14 Around €20 or SEK 200
It wouldn’t be my decision as to whether the patient should or shouldn’t be allowed. [Doctor]

If it’s not part of the law I’m in no right to [...] [Doctor]

Indeed, one interviewee succinctly pointed out the clash between the demands of health securitization and the rights of migrants to healthcare access. On one hand, their job as doctors is to treat patients equally, regardless of citizenship (or potential citizenship) status and provide them with the necessary medical care. On the other, they felt that they also had a duty to keep the public safe from infectious diseases and other epidemiological risks. Within the health securitisation agenda, doctors are thus placed in the awkward position of weighing up their duties to local citizens versus the migrant patient.

[… ] is it denying access? It probably is, it isn’t flagging for treatment, it’s denying access. [Doctor]

The discussion points to larger discourses around the fact that “Health-related norms and policies can be in tension with, or even contradict, immigration norms and policies,” (Wild & Dawson, 2018:68). Many countries (and people) take the nativist approach, believing that the health of citizens ranks higher than the health of migrants. This is particularly pertinent if one is applying for a visa from within South Africa, where anyone, regardless of legal status, is entitled to healthcare treatment. However, this does not work out in practice on account of the xenophobia that exists within parts of the medical establishment. If migrants have difficulty getting access to care, they are naturally going to be in a poorer state of health, and then more likely to be flagged, and then, if the form was used for its intended purpose, denied a visa renewal.

As noted, there is no existing case law in terms of challenging the rejection of a visa on the grounds of what was written on the medical certificate. In general, the incoherence of some of the laws and the existing legislative inconsistencies, as well as the confusion when certain policies are implemented or withdrawn without warning, means that immigration practitioners can find it difficult to create strategies when dealing with Home Affairs. One lawyer mentioned having to try and piece together the various requirements and find ways to argue based on Home Affairs decisions from previous cases. The discussion with the lawyers, therefore, was an
entirely hypothetical one, as they strategized what they would do if confronted with a client who had been denied a visa based on the contents of the medical form.

The subjective nature of the phrasing of the form would be an advantage in this case. One of the lawyers explained how they would take the course of action of consulting another doctor for a second medical opinion which would contradict the findings of the first one. We have established that since there are no regulations around how the form should actually be completed, it is a subjective matter in some regards – which could then be decided on in court. If it was a definite case of one of the listed conditions, then there probably would not be a way around it. However, if there was a shred of doubt, they could argue that it was not really X condition, for example. They would also take into account whether the person could get better, whether they were contagious, and whether their condition was being treated.

This connects with the theory espoused by Bowker and Star (2010), who explain how the systems of categorization are supposed to make things more simple and clear cut, and hide the inconsistencies. However, there is often slippage or tension between categories, which is illustrated in this particular case. While “a state of good health” or “physically defective” are listed on the form as particular static categories, in reality, they are fluid concepts that are incredibly difficult for doctors to define - but can therefore be used to a legal advantage.

Lawyers could also use the legislative inconsistencies to make an argument for why the person should be allowed in the country. For instance, the mismatch between the diseases listed on the form and the ones in the legislation, or the fact that mental health is not covered in the act, or even the fact that South Africa’s International Health Regulations Act is out of date, since the country has technically signed onto WHO’s new version but not yet enacted it into law.

Another tactic would be the financial means approach. Financial resources can also be a way of transforming an unacceptable body into an acceptable one. As one lawyer explained, if someone does have a particular physical or mental disorder, they could still motivate their application based on proof of sufficient funds - that they are able to support themselves and cover the cost of their own care and treatment without needing assistance from the state.

A final option touted would be that of the “good immigrant”. Linking back to Anderson’s (2013:4) theory of the community of value, populated by good citizens, states wish to permit entry to those people who will contribute positively to society, and emulate the values of their morally superior, hard-working citizens. One lawyer said they would argue the hypothetical case based on the “good” that the person could do in South Africa, bringing money
to invest in property, or creating employment through their need for carers, etc. Here the idea of the “good” one could do was linked to a privileged financial status.

Generally, what starts out as a medical issue becomes more than a medical issue. Since the South African Constitution trumps all other laws, if one of those rights was being violated, the lawyer said they’d use that as the key point, rather than wrangling with the Immigration Act. For instance, the Constitution grants people the right to have their families live with them in the country. If a spouse, for example, was denied entry because of their medical report, the rule of the Constitution would trump that of the Immigration Act Prohibited Persons.

While there is not existing case law, that does not mean that people have never been rejected based on their medical results. It just means that this kind of case has never made it to court.

So it's a very expensive exercise. I think that this type of thing is not open to a lot of people unfortunately. And probably a lot of people who would be diseased ...would be the people that might not be able to afford this type of legal advice. [Lawyer]

But somebody who’s a domestic servant won’t have money to go and fight this unless they go to the legal resources centre for someone to go and take it on...[Lawyer]

Since litigation is an incredibly costly procedure, it stands to reason that only those with money can take this route. A lower-income domestic worker from Zimbabwe, for instance, simply does not have the time or the financial resources to pursue this.

For most applicants in the forums, their strategy was to simply go to their family doctor and have them stamp and sign off the form. For others who did not have access to a family doctor who knew their health conditions, they would have to simply go to any GP (general practitioner) – some asked for recommendations in a particular area, for example. Discussion of how to obtain the chest x-ray, however, tended to dominate. Applicants, particularly those abroad in the UK, were concerned about the high costs of getting these done. There was a lot of subsequent debate about whether it was cheaper to get them done in the UK or in South Africa, and which clinics to go to. However, applicants did not appear to have some kind of strategy to “get around the form”, as it were. This can possibly be attributed to the fact that most of the people in the discussion forum were confident that they did not have any of the prescribed conditions. This could also be due to the fact that people reported non-invasive
procedures and an easy completion of the form at the doctor. As such, potential worries were alleviated.

*I just went to my family GP who knew my medical history and just completed the form.*

[Applicant]

*The tests are pretty straightforward. The doctor just asks you some very basic questions about your health and then just confirms if you are healthy enough to move abroad [...] No HIV tests are carried out. Don’t worry, they don’t use needles or do anything invasive.*

[Applicant]

*I have never taken a blood test and I’ve applied for 5 visas already.*

[Applicant]

In summary, the inconsistencies highlighted with regards to the medical form can put the applicant at an advantage or disadvantage, depending on the doctor they encounter. However, as shown through the discussions with the lawyers, there are ways to try and get around an unsatisfactory medical report as well. These different strategies are a direct result of the different interpretations of Bowker and Star’s boundary object – the medical form that travels to and from very different spheres.

Individual Rights

Visa applicants are involved in some kind of disembodied negotiation with the state. Everything deemed by the state and the doctors to be significant about the body is subsequently reduced to a single piece of paper. The state has outlined a list of conditions that it feels are relevant to be disclosed, and the doctors are obliged to respond accordingly when the body comes in for the appointment. These transactions are reformulated and reduced down to what is represented on the medical form. In turn, this form is what is used – at least in theory - to determine whether the condition of the body is of a good enough standard to be admitted into the country.

*Thus, the verified self becomes a perpetual confession in which your body and mind are testifying for you without you even realising it.* (Saunders, 2016)

The body thus transmits a particular discourse here, but it is not actually physically present. Indeed, the South African visa application process is a fairly disembodied one – there is no
mention on the DHA or VFS website of even interviews being conducted. One simply needs to compile all the required documents testifying to one’s identity and character, and then submit them at a visa processing agency or a South African High Commission.

While we may not have evidence that the state uses the medical forms to exclude problematic bodies, state power is still asserted through the mechanisms of this form – the very fact that the body has to undergo some sort of scrutiny, being made vulnerable or even humiliated in the process. You are, essentially, “a database from which some sort of content is extracted,” (Saunders, 2016). The intersection of this kind of medical examination and border control falls under the category of “soft biometrics”; that is, “characteristics that provide some information about the individual, but lack the distinctiveness and permanence to sufficiently differentiate any two individuals,” (Jain et al, 2004:732). This differs from traditional biometrics in that unlike fingerprints and iris scans, your disease profile is not (yet) being used to identify and track you.

But what does this whole process mean for the rights of the individual? For instance, what is the state entitled to know, and perhaps more importantly, what is appropriate for it to know? One lawyer was adamant about not disclosing any more information than was specifically requested on the form. They shared an anecdote about a client with HIV, whose medical report specifically stated that the applicant had that condition. The lawyer encouraged the client to go back to the doctor for a report that simply said they had a chronic condition without specifically naming it. The client ultimately went forward with their visa application using the form which did not mention HIV. This was echoed by one of the doctors I interviewed, who said that “…if you get into the realms of something like HIV – I don’t know if a country has a right to know that information before a person enters the country,”.15 Another medical practitioner, referring to the form’s mention of venereal disease, felt strongly that it was inappropriate to do a genital examination on somebody coming into the country.

Here then comes another ethical issue: that of doctor-patient confidentiality. The form requires a lot of sensitive information to be disclosed – not only one’s personal health conditions, but those that are still subject to stigma such as venereal disease and mental health. The forms are seen by those who process them at VFS16, immigration consultants or lawyers

15 According to UNAIDS (2019), in 2018 at least 20 countries imposed travel restrictions of some form against people living with HIV. Finding updated lists of these countries has proven a challenge, however.
16 VFS is a private company that governments, including South Africa, use to outsource the processing of administrative functions relating to visas and permits. VFS cannot make any decisions regarding applications, but
who may be assisting with one’s case, as well as Home Affairs officials. Confidentiality, then, is somewhat compromised. Furthermore, the form provides room for an entire family of up to eight people to be examined, and have their conditions disclosed on the same piece of paper. This has consequences for individual privacy – what about a family member who does not want the rest to know about a particular illness?

Doctors who had encountered other types of forms which required disclosure of illnesses noted that patients would always have the opportunity to sign and give permission for their medical details to be disclosed – which does not happen in the case of the medical report. One could argue that consent is automatically granted when the visa applicant chooses to submit the form – as one respondent pointed out, if the applicant was unhappy with what was written on the certificate, they could always go to a different doctor for potentially different results. But one could also view this as a kind of coerced consent – you really have no option but to submit a medical form if you want to proceed with your visa application.

Interestingly enough, when the HIV ban was in place from 1987 to 1991, doctors stymied the government’s plan to deport over 1,000 HIV-positive Malawian miners by refusing to disclose the names of the miners because of the inviolability of doctor-patient confidentiality (Fourie, 2006:90). However, this also points to the difficult position doctors can sometimes find themselves in – caught between competing loyalties between what they owe to patients, and what they are required to do by law (Wild & Dawson, 2018:68). This also links back to the discussion in the strategy section, where doctors have to grapple with a situation where individual rights pertaining to freedom of movement, dignity and health come into tension with the rights of the community at large to be protected from infections that could otherwise be prevented by barring entry to a person carrying a particular disease.

Another aspect of the privacy issue is the question of what happens with the information that is submitted to state authorities? Is it digitized, forever to remain associated with your name and passport number in the system? Do the papers sit in a box somewhere in a back office, slowly gathering dust? There is no reference to this on the South African Department of Home Affairs website. We just know that documents submitted to VFS are scanned and then sent

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17 As covered in the research context, South Africa amended legislation to render persons with HIV as prohibited people. This legislation was in place from 1987 – 1991, and was fairly unsuccessful in implementation due to protests by civil society (Fourie, 2006:89-90).
through to a central VFS hub, which is in turn sent on to Home Affairs, as told to me by one the lawyers I spoke to.

The medical testing of migrants based on what the form requires also reveals what could be considered discrimination and stigmatization – a violation of a person’s individual rights - as perpetuated by the state. Both doctors and lawyers were concerned about potentially further stigmatizing particular conditions and discriminating against people for things that they really cannot help, such as a mental disorder or a disability. This reveals a critique that can be levelled against the process of classifying people. Certain categories can have positive or negative values attached them, and by applying a particular label and sorting a person into a particular group, one can (in)advertently contribute to harmful or even dangerous public perceptions of someone’s (medical) status (Bowker & Star, 2000:6).

Some of the respondents emphasized the idea of a condition that someone could not help, i.e. had developed through no fault of their own or was born with. While not expressly stated, one could potentially read into this as potentially “punishing” people for things that they contracted through their own bad behavior. One doctor, for instance, felt it would be appropriate to screen applicants for lifestyle factors such as drugs or alcohol. They also made a link between mental illness and substance abuse, commenting that certain schizophrenias or acute psychoses are often secondary to either intoxication or drugs. This links to Anderson’s (2013:5) idea of “good citizens” as discussed in the theory section. In this example, substance abuse is testament of one’s poor character - even associated with criminality - and thus renders somebody unwanted within the community.

The ill individual body is also an object to be controlled. The idea of control is a pervasive one when it comes to bodies and disease, especially when these bodies and diseases are crossing borders. Respondents felt that people with medical conditions should be permitted entry provided that it is “under control”. This would mean different things according to the specific condition. For example, it could mean someone who has inactive TB or a low viral load for someone with HIV. This is echoed in documents such as the latest iteration of WHO’s International Health Regulations, whose stated purpose is, among others, to control the international spread of disease.

In summary, we see how it is possible for respondents to hold two opposing beliefs at once: on one hand, they do not like the idea of discriminating against people and classifying them on the basis of a particular status, but on the other hand, they are still comfortable sorting people, albeit according to their own categories. We also see how the process of classifying
people in this manner has ramifications for individual rights, ranging from privacy issues to discrimination and violation of one’s bodily integrity.

Threats to Society

Tensions are revealed between the idea of the rights of the individual, as discussed above, and the rights of society as a collective. The concepts of “threat” and “risk” occurred frequently in discussions with the respondents, and in terms of the theoretical concepts discussed in the previous chapter, these concepts also frequently underpin the state’s rationale on screening outsiders. The kind of “threats” that immigrants represent can be more than just biological, as we shall see further on in this section.

*If you had government institutions that allowed somebody to come into a country if they knew they had TB and then that infected somebody. That’s one case of TB that directly affects the life of another person that could have been prevented [*] [Doctor]*

*They obviously don’t want people with contagious diseases in the country and if you limit the number of people with certain diseases coming in, you’ll have less infections in your country. So I get it, yeah. [Doctor]*

In terms of public health, the respondents were clear on the kind of risk that ill immigrants represent. However, their take on the idea of the diseased immigrant body differed from what seems to be the prevailing western perception of outsiders bringing illness to a supposedly healthy country untouched by foreign germs. Rather, the overarching belief seemed to be that there is already so much disease in South Africa, we do not necessarily have the capacity to deal with the health issues of immigrants too.

[*] so if [*] HIV and AIDS is our peak and something that we’re scared of, why would we want to bring more positive people into [the country]? [Lawyer]*

*Why bring those risks into the country if we can’t even control it ourselves? [Doctor]*

*You should sort that out in your country first. [Doctor]*
There is also an element of nativism here – that is, our citizens first, and brings to mind pertinent discussions in health securitization discourse. Specifically, how the health of citizens (or other concerns regarding the potential threat immigrants represent) is often prioritized over the health of migrants by the state and various stakeholders in the immigration process (Wild & Dawson, 2018:68). Public health here appears confined to the borders of the state, and to citizens at that (ibid., 66). Diseased migrants are a problem to be solved, preferably outside of the border, rather than a collective societal responsibility. Here health securitisation serves to create an us-versus-them dichotomy (Bowman, 2018).

At the same time, respondents were also conscious of South Africa’s background of xenophobia and discrimination, as outlined in the research context chapter:

*You also don’t want to do the whole xenophobic thing either, because I wonder what the driving force behind not allowing someone in is.* [Doctor]

* [...] I’m against any form of xenophobia or anything, I’m still very pro-South Africa. So if it’s going to mean a safer country for us all...* [Doctor]

One doctor did offer an interesting counter-opinion, however:

*It seems a little bit irrelevant when we live in a country where venereal diseases are rife, where there’s such a high burden of disease, to put such stringent tests on immigrants.* [Doctor]

Overall though, the doctors felt that screening for HIV, TB and hepatitis was important since those are major health concerns in the country. Their rationale behind this came again from the public health perspective, and concern for the health of the patient - their aim was more to make the patient aware of their condition so that they could get treatment for it and reduce the spread of disease, rather than using it as a motivating factor to have the applicant denied entry. In other words, individual rights triumphed over the “threat to society” factor, and the right to health overcame that of health securitisation.

When it came to the inclusion of mental health disorders on the form, the way the interviewees reasoned around this matter is as follows:
[...] if someone is acutely psychotic or a severe schizophrenic such that they are completely disordered I think travelling could be very bad for them and wherever they are going. [Doctor]

[...] if you aren’t a resident South African then you’d be a burden to the healthcare system if you had a mental health disorder that was debilitating. And then you’d have to be admitted to [a] mental institution which [is] probably the most stressed resource in medicine... If someone has something like schizophrenia and is frequenting mental homes then that adds a major expense. [Doctor]

[...] you don’t really want psychotic people coming into your country. They’re not going to contribute anything financially and they will be a burden... On the other hand... you can have epilepsy and have like one seizure every two years and really it’s not a big deal, it won’t affect your quality of life or productivity much at all. [Doctor]

[...] if they are able to fulfill the task that they want to do and they’re not going to go about killing anybody, if they are controlled, if they’ve been diagnosed and they’re on treatment... obviously we’re not going to admit a whole lot of druggies and... not admit, allow people with psychosis, uncontrolled – cause they’re gonna come and – they do murder people, and we don’t want that. [Doctor]

Overall, their consensus was that the range of disorders listed is extremely broad and includes conditions that do not pose a threat to public safety. However, they justified the consideration of an applicant’s mental state only in the event of conditions mentioned such as psychosis, sociopathy or schizophrenia, where they would want to ensure that the condition was being treated and that the person did not pose a risk of harm to society. Again, here we see the respondents disagreeing with the classification of people at the same time that they advocated for a different kind of sorting. Furthermore, their thinking also reveals another way an ill immigrant can pose a threat to society – through dangerous or violent behavior that could lead to some kind of “harm” of another person.

Another concern mentioned by the respondents in the above quotes was that of the financial burden that a severely mentally ill person represents – more specifically, those with limited funds who would require public health services rather than paying for their own private care. Indeed, becoming a financial burden in some way is a third way that ill immigrants –
either mental or physical - is perceived as a threat to society. This is both a global and local concern, as evidenced by material in the research context section, as well as the quotes from local interviewees. People with conditions requiring medical treatment from government healthcare facilities were reasoned by my interviewees to be additional burdens on a national public health system that is already under-funded, under-staffed and generally under-resourced.

*Why would that law be in place? It’s because the state doesn’t want to take financial responsibility for that person.* [Lawyer]

But there more to this idea of an immigrant being a financial burden. It is not enough to not make use of government healthcare services. A body that does not actively take part in some kind of work, or is incapable of this, is also seen by some as a burden. When reasoning why these health checks may exist in the first place, respondents provided explanations along the lines that one needs to prove fitness for work.

*I suppose as a government you want to just allow people entry into the country who are going to input into your economy. It’s like a capitalist system.* [Doctor]

*I can understand that a country wouldn’t want someone who is incapable of work entering their country on a work permit.* [Doctor]

*I don’t think our purpose is to keep foreigners from coming to South Africa...they’re recognizing that economic growth is promoted through employment, the need for foreign labour [...] So the economy of South Africa is important and they’re recognizing that in the Act.* [Lawyer]

Indeed, the preamble to the Immigration Act dictates that:

*(h) the South African economy may have access at all times to the full measure of needed contributions by foreigners;*

The law constructs appropriate bodies as those that generate income in some form or another. Ironically enough, while the South African state wants your labour, it also does not want you to work too hard – your work is acceptable provided:
(i) the contribution of foreigners in the South African labour market does not adversely impact on existing labour standards and the rights and expectations of South African workers;

In summary for this section, I have shown how the foreign body can represent a threat to the community of value populated by healthy, able citizens. The process of classification through the medical form constructs particular kinds of body – those that are considered “safe”, and those that present a risk. The medical form is therefore a tool that has the potential to screen out those that the gatekeepers, such as doctors or government officials, feel are unsuitable to join this community on a long-term basis.

Summary of Analysis

Here are several key points from the analysis to keep in mind. Firstly, the medical form, the focal point of this thesis, is a singular “boundary object” that travels to a number of different sites as part of the visa process. It allows for cooperation between these different sites to achieve a singular goal. However, it is an object that points to multiple subjectivities, discourses, and interpretations.

Because of these different conceptualisations, the form is enacted differently at each of the key sites that it passes through, whether a doctor, an immigration practitioner, the applicant or a state official. Different sites use different strategies to enact the form accordingly. For example, the discourse of protecting the rights of the individual informs a certain type of strategy taken by doctors and lawyers.

The form is not used in South Africa to exclude people via its testimony of one’s health, unlike the way these kinds of medical checks are used in other countries. This is at odds with the background of xenophobic attitudes that permeate all levels of society, including government agencies. Currently, the form’s ability to exclude appears purely administrative, based on time validity. However, just because there is no existing case law does not mean that people have not been excluded based on health status – just that it has never made it to court.

The way the form is conceptualized and enacted also reveals the workings of state power, specifically how the body becomes the carrier of the border, and how the state works to control which bodies are permitted to enter the country. At the same time, the analysis also reveals the failures of state bureaucracy in the visa application process.
Finally, through its use, the form reveals tensions between protecting the rights of the individual and protecting the rights of the nation. These two contrasting positions are often held at the same time by the individuals who encounter the form. These individuals end up in the role of gatekeepers, whose actions will determine (or at least contribute towards) whether the visa applicant will be successful or not.

Concluding Discussion

There are a number of key issues raised through the existence and use of this medical form. This thesis can be considered a case study, using the South African medical form required for long-term stays to examine issues of classifying people; take a closer look at boundary objects and how they permit multiple interpretations and implementations; and study the workings of state power as it relates to health securitisation. In this discussion section, I will outline a few key implications that have resulted from my study.

Inconsistencies

The multiplicities in terms of interpretations and enactments means that there are numerous inconsistencies that occur. The legislative and interpretive inconsistencies have been covered in the analysis section, but there are others relating to time and financial status that should also be mentioned.

While the form only targets people who are staying in the country for longer than three months, microbes are not subject to the same limitations. So if the form was truly in place to protect the nation from disease, it would logically target everybody, regardless of their origin or purpose of stay. Furthermore, the form may not be older than six months when submitted as part of an application. But between the time of the medical examination, the time of submission and the time until decision, one could technically have picked up multiple diseases. Time-wise, the process as it stands simply does not make sense.

The fact that the form carries some rather vague terminology means that doctors, as shown, can interpret it in a multitude of ways. This means that two people, with two identical states of health, can go to two different doctors and end up with two very different conclusions as to whether they are “physically defective” or in “generally in a state of good health”. And of two people who may have the same disease, why should the one who had the more thorough testing be (potentially) penalized, while the other person who just went to their doctor and had
the form signed off gets to “pass”? Furthermore, if one is dissatisfied with what is documented on their form, they could always just go to another doctor for a potentially different result.

Another inconsistency in this visa application process the way that wealthy people can navigate the system in a way that poor people cannot. Privileged people, for example, have the resources to go private doctors for their medical reports and avoid the long waits in (some) government facilities. Wealthy people can afford the appointment and x-ray costs without a second thought, whilst others may have to struggle to save up, which in turn may delay their application. On the other hand, if one is underprivileged and has the misfortune to go to a doctor who insists on being extremely thorough in completing the form, they can end up with bills for a panel of tests they could never afford in the first place. And, if one tests positive for any of the conditions, wealthy bodies can afford immediate access to treatment while poor ones may have to wait – or not receive treatment at all, depending on where they are applying from.

Finally, as it travels, the form also reveals tensions between the different sites themselves. These sites do not talk to each other, and as the colloquial expression goes, “The left hand doesn’t know what the right hand is doing.” The lawyers interviewed thought that the doctors might have guidelines from the medical fraternity or learn at medical school how to complete the form, while the doctors thought there might be some legislation or regulations around how to fill it in. Home Affairs does not reveal much of anything to any of the other actors. And within the legal framework that governs the form, there are several mismatches and contradictions, which in turn complicate matters for the other sites.

**Broader ethical issues**

This thesis also points to the issues that arise with the use of classification systems that are intended to simplify bureaucratic procedures and assist with administration. This is particular pertinent when it comes to the sorting of people:

We have a moral and ethical agenda in our querying of these systems. Each standard and each category valorizes some point of view and silences another. This is not inherently a bad thing - indeed it is inescapable. But it is an ethical choice, and as such it is dangerous - not bad, but dangerous...For any individual, group or situation, classifications and standards give advantage or they give suffering. (Bowker & Star, 2000:6).
Indeed, the use of this form points to discourses around several broader ethical questions – ones to which I have no answer, but which are important to raise nevertheless. What are the ethics around requiring medical examinations of immigrants before they are permitted entry into a country? What is the state entitled to know about an individual’s health conditions? What constitutes an ethical way of obtaining this information? Which conditions, if any, should render an individual a person non grata? How do you prevent genuine public health concerns from being securitized by states eager to exercise their sovereign rights to control the movement of people across their borders? And how do you protect public health without infringing on the rights of the individual – particularly when it comes to the role of doctors?

Other scholars have tackled some of these questions to varying degrees. For example, Wild and Dawson (2018:68) argue for a social justice-based approach to public health, built upon the values of a shared humanity and human rights. They point out that effective public health policies cannot be confined to the citizens within a particular state’s boundaries, but should rather take a broader, global perspective. Indeed, when it comes to the health and wellbeing of migrants, the authors advocate that an ethical analysis of migrants’ access to healthcare needs to take all phases of migration into account – before, during and after transit, and not just when they arrive in the country (ibid., 66). Abbas et al (2018:8) echo this belief that “The principles of public health equity mean that medicine must be used to assist human populations in distress.” However, they still advocate for epidemiolocal screenings for incoming migrants, claiming that these are “a legitimate tool to better study the profile of migrant populations and understand their needs,” (ibid., 7).

This idea of invasive state control over the body also comes up in discussions in the related field of biometrics. The body is playing a greater and greater role, not only when it comes to identification for border crossings, but also as a testament to one’s suitability for a visa or citizenship. According to Salter (2006:184):

[… ] the global mobility regime foster[s] conditions under which we organize ourselves into international bodies and characterize those bodies as national or stateless, laboring or leisured, healthy or diseased, and safe or pathological […]

He addresses several of the concerns raised in the analysis chapter and links the medical screening of bodies to the concerning expansion of state policing powers. This has implications for individual rights in terms of consent (the body testifying for you), the storage of the data
without any kind of checks and balances, and the ways in which particular bodies are
constructed through stereotypes and subsequently stigmatized (ibid., 185).

Who does the form target?

The research context chapter outlined the atmosphere of xenophobia in South Africa. Based on
this, I expected to find the form used in a discriminatory way. However, it is evident that the
form does not do what I expected it to do – it does not match up with the prevailing societal
discourse. Rather, it targets those who become what I have dubbed “semi citizens” –
international students, labour migrants, spouses joining their partners, retirees and the like.
Within this hierarchy of desirable outsiders, it is the tourists and business travellers that appear
to rank the highest. They are not required to have the medical checks done for their visas – and
some passports are exempt from any kind of visas at all. (Only for short-term stays though.)
We can assume that this is because implementing these health checks for short term visas (stays
under three months) would devastate the tourist industry, and deter business investments.
Tourists and business travellers are thus privileged bodies, capitalist bodies, bodies that invest
substantial sums of money into the South African economy, and are consequently welcomed,
regardless of what bacteria may be accompanying them.

When looking at the nationalities that are targeted in South Africa’s xenophobic attacks,
they include other African nations, as well as those from Bangladesh and Pakistan. These tend
to correspond with the nationalities that make up the bulk of those receiving both temporary
and residency permits in South Africa (Stats SA, 2017). In this context, South Africa is
generally the more prosperous nation, and immigrants from these countries would be perceived
as having a more precarious financial status.

In an indirect way, however, there are certain ways that the form potentially targets
specific demographics. If wealth can be a mitigating factor, then poorer people are at a
disadvantage - and poverty is skewed in terms of black bodies (Farmer, 2004; Patton, 2002).
And as mentioned, the form lists neglected tropical diseases of leprosy and trachoma, which
are found in specific low-income countries linked with specific ethnicities. Furthermore, poorer
people are more likely to be sicker in certain contexts, due to socio-economic factors: limited
access to healthcare, limited financial resources to pay for treatment or travel to get it,
unsanitary living conditions, etc. (ibid.). This in turn could then jeopardize their “passing” of
the medical exam.
While the form appears to fulfill a mere administrative purpose rather than a health securitization one, that does not alter the fact that it has the potential to be mobilized for political ends. The HIV ban in the late 1980s, for instance, as well as playing into the global fear around the disease also served to try prevent exiles returning home at the end of Apartheid (Fourie, 2006:89-90). The atmosphere of xenophobia in the country shows no sign of abating – indeed, the main opposition parties played up their anti-immigrant stance as a way to court voters in the most recent South African election in May 2019 (Davis, 2019; Chutel 2019).

Indeed, links to discourses around health securitisation were evident in the discussions with the interviewees. While they emphasized the importance of individual rights, ideas about what constitutes a “good citizen” and perceptions of threats to the nation were also present. Proposed changes to the Immigration Act, published in a July 2017 white paper, show that policy makers still have not moved away from the old stereotypes of foreigners bringing crime, for example. The new proposals take a risk-based approach to migration management, which certainly has ramifications for the expansion of health securitization as well. The proposals also aim to delink residency from citizenship, which will make it even more difficult to obtain the latter. According to an immigration lawyer published in South Africa’s Mail & Guardian:

The white paper vilifies human rights organisations and legal practitioners, as well as the judicial process, as abusers of the systemic loopholes in our legislation and policy framework, at the expense of government. It laments the fact that judicial decisions are drivers of policy… In reality, litigation ensues as a last resort, when the possibility of finding an accommodation with the state fails. There unfortunately exists an inordinate level of litigation by civil society against home affairs because of the adversarial approach to service delivery and the resolution of policy standoffs. (Eisenberg, 2018)

Finally, what would it mean if South Africa ever did end up updating their legislation in line with WHO’s 2005 International Health Regulations, to which the country is a signatory? It would require the state to remove the specific diseases of plague, cholera and yellow fever from the law which would render someone a prohibited person, replacing them instead with the general “public health emergency of international concern” (Wilson et al, 2008:44). However, the medical form does not correspond with the current legislation anyway, so changing the law might not have much of an impact. At some point, somebody in the administration would need
to take notice of this as-yet overlooked document, with all the discrepancies described, and eradicate or reconceptualize it. Indeed, my aim with this thesis is not to advocate for more regulated procedures when it comes to assessing migrant health and suitability for a South African visa. Rather, it began as an exploration into the function of the contradictory medical form, which has ultimately showcased the issues that arise (or can arise) from this kind of sorting, and highlighted the numerous problems which occur when the state attempts to control bodies in this manner – particularly in the realm of individual rights.
Appendix A

Medical Form

Republic of South Africa
Department of Home Affairs

Medical Certificate

Conditions of a Recurrent Nature

Although the person(s) may be generally in a good state of health at the time of the examination, it would be appreciated if the medical officer/practitioner could furnish details of any disease, condition or defect the person(s) has/have suffered and which might recur.

I hereby certify that I have examined the following person(s):

1. .................................................................
2. .................................................................
3. .................................................................
4. .................................................................
5. .................................................................
6. .................................................................
7. .................................................................
8. .................................................................

and find him/her/them—
(a) not mentally disordered or physically defective in any way;
(b) not suffering from leprosy, venereal disease, trachoma, or other infections or contagious condition;
(c) generally in a good state of health;

except for the following defects observed:

(Please type or print)

Name of person(s) | Details regarding the disorder, disease or disability, the seriousness thereof and the treatment, if any, prescribed/recommended

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Official stamp and address of medical officer/practitioner

Signature of medical officer/practitioner

Date

Int. code

* "Mentally disordered" includes the following:

200-239 All psychoses.
230 Neuroses.
301 Personality disorders.
302-304 Addictions.
305 Behaviour disturbances of childhood.
310-319 All forms of mental retardation.
320-319 Epilepsy and other forms of degeneration of the central nervous system.
Appendix B

Radiological Form

Note:

(1) A radiological report of the chest is required in respect of every prospective immigrant 12 years of age and over.

(2) The radiologist must insert the names of the prospective immigrants examined by him in the space provided for that purpose on the form. Unused spaces must be crossed out.

(3) A separate report is required in respect of every applicant suffering or suspected to be suffering from tuberculosis.

I hereby certify that I have radiologically examined the chest(s) of the following person(s) and that I could find no signs of active pulmonary tuberculosis.

Name:

(1) __________________________________________

(2) __________________________________________

(3) __________________________________________

(4) __________________________________________

(5) __________________________________________

(6) __________________________________________

__________________________________________  Official stamp and address of Radiologist/Hospital:

Radiologist

Date: ___________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Appendix C

Information Letter

Hi there

My name is Hannah Atkins, and I am a South African second year master’s student at Linköping University in Sweden. My degree is in the field of Ethnic and Migration studies, and I am currently working on my MA thesis focusing on the medical testing of migrants for visa purposes. Specifically, I am interested in the practice of medical testing people for visa applications to see whether they are deemed “acceptable” according to existing health standards and permitted entry into the country.

As a MA student, I follow the principles for research ethics. This implies that your participation is voluntary and you have the right to cancel the interview or choose to refrain from answering certain questions. You also have the right to request information removed from the interview, but due to time constraints, this must be done within the week after the interview is conducted. The interview will be recorded on tape and transcribed. I will, to the best of my ability, anonymize all transcriptions, i.e. no names or places will be used.

I will treat the interview material with care, and unpublished material will not be distributed. All the interview material will be stored securely in line with the EU General Data Protection Regulation and will only be available to me. Once my thesis is complete, the recordings will be deleted.

My thesis will be archived in the university’s library, and available through Linköping University Electronic Press.

My thesis supervisor is Anna Bredström, Senior Lecturer at the Institute for Research on Migration, Ethnicity and Society (REMESO) at Linköping University. She can be contacted at anna.bredstrom@liu.se or +46 11 36 32 42.

Thank you so much for your time.
Appendix D

Questions – Lawyer

- So, I am interested in the medical reports that some VISAs to SA require, are you familiar with them? Do they come up as relevant in cases that you represent? In what ways?
- Do you know when these reports became part of the requirements for the visa process? (If they know this, might help me to find more debates.)
- Have you encountered any cases of applicants being denied visas due to the status of their medical report? If so, are you able to tell me more about it? (Additional prompting questions here as needed e.g. How did that work? What happened next?)

OR

- Have you heard of any cases of applicants being denied visas due to the status of their medical report? If so, are you able to tell me more about it? (As above)

If NO to both those questions, then:

- Hypothetically, can you walk me through what would happen if someone came to you, requesting an appeal for their visa application, due being rendered a prohibited/undesirable person on the basis of their medical report?
  - Is this a thing that even happens?
  - Is it possible to appeal on these grounds?
  - What would this process look like?
  - Are certain conditions more acceptable than others, e.g. having epilepsy versus venereal disease?
  - Would it matter depending on the kind of visa they are applying for e.g. permanent residency as opposed to a work permit?

- Who ultimately takes a look at the reports submitted with applications and makes the final decision?
  - Would it just be a standard Home Affairs official, or someone with a health background? (So in other words, do you know who is interpreting what is
During my research, I found a lot of discrepancies into how the medical report is completed – specifically, some people just go to their family doctor and have them sign it off, and other medical centers list blood tests as a necessity to check to see if the applicant has any of the physical conditions listed on the form. What are your thoughts on this?

The medical report also makes reference to those that the doctor defines as “mentally disordered”, and unlike the physical conditions, a set list is provided with the accompanying ICD-9 codes which cover a wide spectrum of conditions from autism to anxiety. However, there is no mention of mental illness in the prohibited persons section of the Immigration Act of 2002, it just says “Those infected with or carrying infectious, communicable or other diseases or viruses as prescribed”. However, they do make mention of “Anyone who is or is likely to become a public charge” and “anyone who has been judicially declared incompetent”, which according to the research I have done, are reasons some other countries want to know about mental states of applicants.

- Is my interpretation of the law here correct – if declared with one of these disorders, would someone be barred entry?
- Would someone with a diagnosed mental illness need to prove that they then would not be likely to become a public charge?
- Is there anything to stop someone from just omitting this information from their form? Would a doctor technically be liable? For example, a family doctor not disclosing that the applicant has generalized anxiety disorder, ICD 9 – 300.

The legislation for the prohibited persons based on disease is outdated (South Africa’s International Health Bill of 1974) and considers things such as the plague and smallpox. What are your thoughts on this apparent disconnect between what the law states and the biological realities?
Appendix E

Questions – Doctor

- So, do you meet patients/clients that need the medical reports? If so, are they a specific group of applicants, or do their motives for staying vary?

- Have you completed this medical form for an applicant before? (If no, phrase the next question as hypothetical.) Can you walk me through what would happen at an appointment? (Additional prompting questions here as needed e.g. So why did you do that? How did the patient react?)

- For instance, how would you define or qualify someone to be “physically defective” or in a “good state of health”? Do you use any particular diagnostic tools? Are there any requirements to do so? Are there other medical professionals involved in this process, e.g. radiologists or lab assistants?

- During my research, I found a lot of discrepancies into how the medical report is completed – specifically, some people just go to their family doctor and have them sign it off, and other medical centers list blood tests as a necessity to check to see if the applicant has any of the physical conditions listed on the form. What are your thoughts on this?

- Do you think it matters who the applicant is and where they’re coming from/what they are coming here to do?

- From your point of view, are there biological justifications for screening for the particular diseases listed on the form in terms of permitting someone entry into a country?

- In your opinion, what are the justifications, if any, for excluding entry based on the mental disorders listed on the form? It’s quite an extensive list, and even people with something like diagnosed anxiety would be considered mentally disordered according to the form’s specifications.

- The legislation for the prohibited persons based on disease is outdated (South Africa’s International Health Bill of 1974) and considers things such as the plague and smallpox, which are vastly irrelevant health concerns now. What are your thoughts on this apparent disconnect between what the law states and the biological realities?

- Where does doctor-patient confidentiality fit into all of us? Some of the information required to be disclosed is quite sensitive, such as venereal disease or mental illness.
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