



# **Gendering the care/control nexus of the humanitarian border: Women's bodies and gendered control of mobility in a EUropean borderland**

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# Gendering the care/control nexus of the humanitarian border: Women's bodies and gendered control of mobility in a EUropean borderland

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## Abstract

Building upon and contributing to a feminist geography of borders, the chosen methodological approach examines women's bodily experiences at a Southern EUropean border, the Spanish enclave of Melilla. Drawing on three months of ethnographic fieldwork, this article scrutinises the care interactions unfolding in a Centre for Immigrants between medical humanitarians and women residing there in their position as both migrants and patients. The analysis foregrounds the gendered forms of domination that the care function of the humanitarian border entails. I argue that medical humanitarians are vested with the power to decide over women's mobility in the name of care on the basis of an entanglement of administrative and medical procedures in this border context. While women are subject to greater humanitarian intervention due to the association of their embodied states with vulnerability, the biopolitical migration management of the border grants medical humanitarians a decision-making authority. The article uncovers how medical humanitarianism, enmeshed in the border regime, yields gendered constraints from practices of immobilisation to imposed practices of mothering. It traces the rationale for these practices to racialised and gendered processes of othering that usher in perceptions of undeservingness and sustain a humanitarian claim for biopolitical responsibility over these women's mobility.

## Keywords

Borders, gender, humanitarianism, body, care, migration

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## Introduction

They arrive here without anything, I speak of the sub-Saharanians, because they come from jumping over the fence and they come with nothing. And here they're given food, they're given a roof, they're given medicine. They have a doctor like any resident of Melilla. They're given a set of clothes, they're given a blanket, a pillow, bed sheets, the laundry, each week bed sheets and towels are changed, they're given a kit to wash their clothes. – Rosa, nurse at an NGO inside the CETI

Rosa's words emphasise the care function of the Centre for the Temporary Stay of Immigrants (CETI) situated at the Spanish southern border of Melilla. Rosa, a middle-aged woman and an experienced nurse, carefully enumerated the items migrants are given by social workers, a listing exercise that continued for a few minutes in an attempt to exhaustively name all the material objects that migrants receive either upon their arrival or during the course of their stay. And yet, Melilla, this Spanish enclave in North Africa and EUropean<sup>1</sup> border, has come to epitomise along with Ceuta, the other Spanish enclave and territorial border between the EU and the African continent, the militarisation of borders in both journalistic and academic accounts (Andersson, 2016; Johnson, 2013). Photographs of the city's triple fence and in particular of migrants climbing the last barbed wire fence before attempting to enter Melilla form by now part of a shared imaginary around the notion of 'fortress Europe'. While pictures of Melilla's multi-layered border fences have toured the world, it became almost a de-territorialised symbol of the military securitisation of borders. Situated about a 100 kilometres westwards from the Moroccan–Algerian border and a little less than 400 kilometres distant from its 'sister city' of Ceuta, Melilla is separated from mainland Spain by 225 kilometres of Mediterranean Sea, a six-hour boat journey. The progressive 'hardwiring of the frontier' (Andersson, 2016) over three decades has created an enclosed Spanish city and a EUropean enclave.

Rosa's proud enumeration of all the forms of assistance available in the Centre thus unfolds against the background of violent practices of repression, within spaces where the barbed wire fences cut and mutilate the bodies of those attempting to cross them (Frías, 2018). As evidenced by Reviel Netz (2004), barbed wire, far from an incidental feature of fences, represents a central tool of modern control over space that witnessed a rapid generalisation from its initial implementation by European settlers to control animals in West America to its widespread use against humans from colonial wars to concentration camps to contemporary borders.<sup>2</sup> The borderland of Melilla represents one instance of the humanitarian border, combining violent deterrence with forms of care, that emerged at various points of contact between the so-called global North and global South (Walters, 2011). The Centre's geographical location embodies in and of itself the tension between care and control at the border: situated about 300 metres away from the militarised fence, the CETI is meant to host migrants in Melilla and cater for their material needs during their stay in the enclave; however, it fulfils its function the furthest distance possible away from the *Melillenses'* (inhabitants of Melilla) gaze and as close as possible to the militarised fence. With the barbed wire fences remaining in the visual horizon of the persons residing in the CETI, the work of the international NGO providing primary medical care inside the Centre, officially run by the Spanish Ministry of Employment and supported by EUropean funds, constitutes a revealing example of how care runs through the apparatus of border management.

Beyond a focus on direct patterns of violence at the physical border, this article digs into forms of domination produced by the care dimension of the humanitarian border. Drawing on two bodies of literature, feminist political geography and the care/control dyad of the humanitarian border, I argue that the entanglement of administrative and medical procedures within border management produces specific constraints for women on the move. With its focus on pregnant women and recent mothers, this article posits the scale of the body as particularly revealing of how border enforcement operates through bodies, engendering different implications for men and women. I seek to contribute to an embodied feminist geopolitics of migration (Hyndman, 2019; Massaro and Williams, 2013; Mountz, 2011; Pratt, 2005) placing women's bodies at the heart of the analysis. The other strand of literature that nourishes this article revolves around the notion of the humanitarian border that foregrounded the care/control nexus (Ager, 2008; Pallister-Wilkins, 2015) as constitutive of the 'humanitarian borderscape' (Pallister-Wilkins, 2018a).

Although feminist geopolitics have engaged with gender and the body for around two decades, the gendered implications of the caring function of the humanitarian border remain under-researched. Away from the border context, Miriam Ticktin (2011a) foregrounded the gendered dimension of humanitarianism by tracing how a medicalised, and thus reduced, understanding of gender-based violence facilitated its introduction into the humanitarian portfolio. In relation to the migration journey, previous research drew attention to the gendered implications of securitisation in endangering the migration trail (Freedman, 2016a; Tyszler, 2018), increasing, among other consequences, the risk of sexual violence (Freedman, 2016b). Within criminology studies, researchers looking into the work of government contracted NGOs with unaccompanied minors for the Australian community detention and release programme, argued that children 'experience the greatest level of intervention under the guise of care' (Gerard and Weber, 2019: 282). Here too, my interest lies in the level of intervention into women's lives that care facilitates in the border context.

I intend to expose how power relations within the care dimension of the humanitarian border produce specifically gendered implications whereby bodies are targeted as a site of intervention that materialises a form of domination. The article seeks to nuance accounts that assume that women and children are systematically privileged in the context of humanitarian intervention (Phillips, 2009; Williams, 2016: 32 citing Carpenter, 2003 ) by uncovering the ways in which medical humanitarianism at the border yields specifically gendered constraints from practices of immobilisation of pregnant women to imposed practices of mothering for recent mothers. In doing so, the article addresses the challenge of understanding 'what the border does to humanitarian practice' (Pallister-Wilkins, 2018a: 133) through the specific case-study of the work of a medical humanitarian organisation embedded within the broader system of migration management at a Southern European border. It relies on a qualitative research into care interactions unfolding in the setting of a medical NGO providing primary care services in the CETI. The first section engages with writings by feminist geographers around the analytical scale of the body and situates this contribution within the literature on the humanitarian border. After a presentation of the methodology underpinning the ethnographic data collected, I examine how administrative and medical procedures become intertwined in the governance of migration in Melilla. The second empirical section traces how medical humanitarians have come to exert different forms of migration control over women residing in the Centre. This brings me to interrogate the moral constructions that characterise healthcare professionals' interventions vis-à-vis the Centre's women residents, in their position as racialised and gendered migrants as well as patients. The final

section foregrounds how a gendered understanding of humanitarian responsibility facilitates the multiplication of constraints imposed on women's mobility.

### **Women's bodies within the care/control nexus of the humanitarian border**

The body is a relatively recent scale of analysis for political geography, yet feminist approaches relating the body to the operation of power and the definition of space have displayed a marked growth since the early 2000s (Mountz, 2018). Interest in the scale of the body allows, in Vanessa Massaro's and Jill Williams' (2013) words, 'an analysis of the way geopolitical processes are experienced unevenly across differently situated populations' (570, see also Dixon and Marston, 2011; Sharp, 2007). Such attention to the body enables more specifically the identification of concrete manifestations of power by carving out an analytical path from the individual, the intimate and the local, to the structural, the political and the global, following the feminist historic claim that the private is political. Linking these levels of analysis is here inspired by the 'institutional ethnography' outlined by Dorothy Smith (1987, 2005), a methodology shaped by feminist standpoint theory that foregrounds the situated character of knowledge and encourages adopting the perspective of women's everyday lives to uncover the workings of gendered oppression (within political geography, see Dowler and Sharp, 2001). Borders are, furthermore, particularly meaningful sites of investigation as they crystallise the workings of geopolitical forces onto bodies (Mountz, 2011). Importantly, migration control at the border shapes the corporeal experiences of migrant persons differently, owing to classed, gendered and racialised understandings of otherness, as power operates through intersectional patterns of domination. An embodied feminist geopolitics of migration thus locates 'power at the scale of the body' (Mountz, 2004: 325; see also Hyndman, 2004) to achieve an examination of how different forms of violence come to be exerted (Massaro and Williams, 2013). Beyond the shared consensus among feminist geographers that power affects social groups in different ways, the challenge consists in analysing the specific ways in which borders affect women's and men's lives and bodily experiences, in other words the ways in which legal abandonment is gendered (Pratt, 2005). Jennifer Hyndman and Wenona Giles (2011) contended that the very notion of mobility is gendered in that refugees in protracted situations are feminised by being made to stay put, portrayed as passive and disciplined, as opposed to masculinised, active and thus threatening representations of asylum seekers attempting to reach European countries outside of resettlement programmes. In the context of the Australian war against migrants, and drawing a continuity with the gendered discourse on women and children in war, Kristen Phillips (2009) convincingly argued that 'male and female bodies are stripped of political status' in different ways with male bodies 'stripped of political status so that they may be subject to violence' and female bodies 'constituted primarily as reproductive bodies' (132–133).

Turning now to the notion of the humanitarian border, a brief detour through the concept of humanitarianism helps situating the theoretical background of this article. Following Didier Fassin (2012), humanitarianism is defined as a mode of governing those affected by poverty, wars or exile that engages states, international organisations, NGOs and individuals. Fundamentally, humanitarianism relies on and reproduces unequal relationships between those receiving and those providing aid (Ticktin, 2011b; Williams, 2016). Drawing on a Foucauldian approach (Foucault, 1978/2004), the notion of a humanitarian border conceptualises the borderland as a biopolitical space where mechanisms of border

enforcement that cause death are paradoxically intertwined with policies that aim at preserving life. William Walters (2011) described the progressive emergence of such a combination of care and control within border management as ‘the birth of the humanitarian border’: ‘Border regimes are composed not just at the level of strategies and technologies of control, but also at the level of strategies which combine elements of protest and visibilization with practices of pastoral care, aid and assistance’ (155). The concept captures two related developments: first, a growing number of humanitarian actors are providing assistance to people on the move, in borderlands as well as along migration trails, and the scope of their activities is expanding (Perkowski, 2016). Second, national governments and the EU have increasingly adopted a humanitarian rhetoric leading to the co-optation of the human rights discourse (Vaughan-Williams, 2015) and the emergence of a performative ‘policing-humanitarian nexus’ (Albahari, 2015: 37). The care dimension of the humanitarian border is implemented by border agencies themselves as well as by a changing landscape of humanitarian organisations (Grotti et al., 2019). Several studies have traced how humanitarian framings played out in the practices of border police (in the US: Williams, 2015; in Turkey: Isleyen, 2018). Delivering care at the border is also carried out by international NGOs and several medical humanitarian organisations have come to play a major role, such as Doctors without Borders, Doctors of the World and the International Committee of the Red Cross. Medical humanitarianism thus fulfils a key role in the making of the humanitarian border. It can be defined as ‘the provision of biomedical, public health, and epidemiological services in conditions of emergency or crisis’ (Abramowitz et al., 2015: 1). Importantly, the border as a space of humanitarian work, i.e. of a hierarchical relationship of victims and saviours (Perkowski, 2016), is not only entangled with the military and violent dimension of the border, but constitutes a consequence of this very militarisation: the more particular border crossings have become a matter of life and death, the bigger the space for humanitarian intervention (Albahari, 2006; Walters, 2011). A prominent point of comparison to the Mediterranean border between European and African continents is the US–Mexico border, about which Jill Williams (2016) developed an analysis that equally applies to the border situation in Melilla: rather than undermining the militarisation of borders, ‘the humanitarisation of border enforcement via the safety/security nexus (...) justifies [their] continued militarisation and securitisation’ (28). Against the background of the increasing sophistication of technologies used to control people’s mobility and their lethal consequences (Albahari, 2006), the role played by medical humanitarianism in border spaces has arguably become more prominent.

## Methodology

This article results from fieldwork I conducted in Melilla in 2016 over a period of three months and an additional shorter stay in early 2017. During that time, I visited the CETI several days a week for six weeks to meet with women residing in the Centre and to interview different categories of social workers and healthcare professionals. The research was granted clearance by the Ethical Assessment Committee of the European Research Council Executive Agency as well as by the ethics advisory board of the EU Border Care project hosted at the European University Institute. Authorisation to conduct interviews in the CETI was granted by the director of the Centre after my request had been positively answered by relevant Ministry authorities in Madrid.

Over the course of my fieldwork, I conducted 12 semi-structured interviews with health professionals, nurses in their majority, who provided care to migrants accommodated in the Centre, and to whom I refer here as ‘medical humanitarians’. Interviewees also included



several administrative officers and social workers. My fieldwork equally entailed 18 interviews with migrant women residing in the CETI and many additional informal conversations with several of them on the occasion of time spent inside the Centre. After I had been introduced to a group of women by a social worker, interviews unfolded following snowballing and word-of-mouth. Interviews would usually take place outdoors, either on the benches adjacent to the rooms or seated on the ground a bit further away for more privacy, and at times in the interviewee's room if her roommates were not present (a room was shared by up to eight women). The women I interviewed migrated from Syria, Algeria, Morocco and Yemen. Women and children represented 34% of the Centre's residents at the time of fieldwork in 2016. Eight in ten women respondents had applied for asylum. Importantly, the use of the term 'migrant' does not imply any distinction between those seeking asylum and those who did not submit an asylum application. Notwithstanding its use by the media, this term should not be understood as implying the notion of 'economic migrants'. Rather, the use of the term 'migrant' merely describes the fact that research participants have crossed international borders and does not interpret their motives for doing so. All names are pseudonyms.

### **Medical humanitarianism and migration control in the Spanish enclave of Melilla**

The case-study of the Centre for Immigrants in Melilla illustrates the ambivalent durability of medical humanitarianism in the context of the humanitarian border. Owing to the framing of migration as a 'crisis' (Anderson, 2017; Sigona, 2018), varied forms of medical humanitarianism have developed involving a growing array of humanitarian actors and shifting configurations of care (Grotti et al., 2019). The medical NGO under study here provided care inside the Centre for several decades. While the number of migrants residing in the Centre more often than not exceeded the initial accommodation capacity, the collaboration between the administration of the Centre and several NGOs had been consolidated over the years fostering a sense of stability and familiarity between various categories of workers (Sahraoui, 2019). The presence of medical humanitarians inside the Centre had thus become an ordinarily feature of the Centre's life. And yet, the crisis discourse, re-enacted at each arrival of groups of migrants, created recurring emergencies. The everyday care work of nurses and doctors thus took place in an ambivalent context enmeshed in both continuity and crisis. In the CETI, medical humanitarianism became institutionalised in that administrative and medical personnel worked side by side in close cooperation. The NGO spaces were symbolically inside the administration's building. Professional trajectories of health-care workers resembled those of administrative personnel, some had been working together for over a decade, creating a dense net of social interactions. As a result, the formal distinction between those in charge of the administration of the Centre and those responsible for providing care bore little meaning in the everyday management of the Centre's activities. The embeddedness of humanitarian activities within the administrative running of the Centre became apparent in numerous everyday practices, from the constant flow of information, to shared work spaces, to the mobilisation of translators across these spaces. The permanence of the form of medical humanitarianism encountered in the Spanish enclave contrasts with the emergency and temporariness usually associated with humanitarian interventions but reflects the fundamental entanglement of border management with some forms of care, characteristic of the humanitarian border. In his genealogies of care and confinement at Southern Italian borders, the anthropologist Maurizio Albahari (2015)

argues that ‘a humanitarian logic de facto enabled the institutionalization and centralization of migrant detention’ (44). Rather than a disruptive intervention within processes of securitisation, humanitarian assistance pertains to the very formation of securitisation and control. In the Centre for Immigrants in Melilla, it appears that the medical procedures carried out by the NGO are formally part of the registration process. The Director of the Centre described the identification process as follows:

When they [migrants] arrive, they are first attended by nurses, if it’s possible they’re cared for here otherwise they’re addressed to the hospital. [...] Then they’re sent to shower, they’re given clothes, food and then the whole “mechanics” starts, they’re going to the police, 50 have been sent today and 50 tomorrow, that’s how we’re proceeding to register and identify them. Then, what is done with them is a blood test, all residents have a blood test done to detect diseases that they can carry and then the police takes finger prints and registers data.

Medical humanitarianism at the border finds itself at the intersection of medical and administrative logics as a result of being fully embedded in the Centre’s mandatory procedures. Being seen by a nurse and passing a series of medical examinations constitute a protocolised step within the process of police and administrative registration as resident in the Centre. This form of healthcare provision appears to be determined by the biopolitical management of bodies at the border, tethered to the border’s function of sanitary surveillance. The meanings of healthcare services become in this context multifold, if not entirely subsumed under the rationale of migration deterrence and control. At the US–Mexico border, Jill Williams (2015) found that ‘in most cases care is also provided in ways that privilege timely deportation over corporeal care’ (12). Making medical humanitarianism part of the ‘official reception’ reveals how care and border enforcement are profoundly entangled, but also how ‘care’ itself can become constraint and coercion if the administrative logic determines the purpose of the care provided. Biopolitics for the non-citizens is not mostly about optimising life, it is above all about managing and surveilling bodies’ mobility at the outskirts of the sovereign space. As noted by Polly Pallister-Wilkins (2018b): ‘Hotspots aim to capture the will-to-care present in modern liberal politics and the modern state with its focus on the security of populations, and put care to work in the most efficient and effective way for processes of control’ (14). The care provided upon arrival responds primarily to an objective of disease control, illustrating a ‘long legacy of national border control for public health’ (Bashford, 2007: 11). Humanitarian care is framed at the border as a top down medical apparatus to ensure the biosecurity of the bodies accommodated in the camp. Against this background, Rosa, the nurse quoted above, recounted tensed interactions when it came to blood tests:

So “profile Africa” entails hepatitis A, hepatitis B, hepatitis C...and if the hepatitis C comes positive you need to confirm this hepatitis, so you need to take blood once again. You need to take a tube, so they ask why... why so much blood, that we’ll leave them without blood, why so much blood, do we sell it... so we explain, but they don’t seem very convinced. And if on top of that a sample doesn’t get to the hospital or gets lost, it fell down or was broken, and we have to do it again... forget it... they come with such a face... I understand, some of them had to do it three times because the sample didn’t get there, or it was damaged, or any problem, many things can happen.

The ambivalent meaning that care can take in the border context further materialises in the use by healthcare professionals of the ‘administrative reason’ to be able to carry out their



humanitarian care. Clara, a nurse at this NGO, explained how she had to convince residents to get the blood tests done and to sign the informed consent forms since these medical exams were necessary for the person's (potential) future mobility:

Often they don't want to have the tests done, to open a file, but we convince them because we tell them that if they don't have an entry file they can't have one for exit, so that's how it goes.

The structure of care relations within medical humanitarianism at the border revealed a twofold fundamental inequality: that between receivers in need of assistance and benevolent givers that defines the humanitarian relation on the one hand, and that between non-citizens, deprived of rights, and national citizens on the other. This structure of relations facilitated the use of the 'administrative reason' to administer healthcare, granting healthcare workers a latent authority over non-citizen patients. The situation at hand is a case in point of how humanitarianism 'upholds the territorialised framework of differential rights upon which border enforcement efforts are based' (Williams, 2016: 34).

### **Medical personnel's authority over migrant women's mobility**

It is time to turn to the ways in which this articulation between administrative and medical procedures produce gendered constraints for pregnant women and recent mothers. Among the battery of tests that migrants need to undergo upon arrival, a tuberculosis test is not supposed to be administered to women if they are pregnant. Healthcare professionals therefore asked newly arrived women whether they were pregnant, though they also emphasised they believed some women were not willing to disclose their pregnancy out of fear that revealing this information would impact negatively the pace of their migratory journey. Clara, an experienced nurse within this medical NGO, explained:

Normally they tell us if they're pregnant because we do a "Mantoux" [TB test] and if she's pregnant we can't administrate it so we very much insist "are you pregnant?" Because I have to do a test that is dangerous for the baby, so then they tell us the truth.

Interviews with migrant women clearly indicated that one of the main worries associated with the pregnancy was that this would delay their migration, since most of them had already travelled for months, some for years as was often the case for Syrian families who had spent several years in Lebanon and/or in various African countries prior to their arrival to Melilla. Interactions as the one evoked by Clara thus put pressure on migrant women to disclose a pregnancy that some of them preferred to keep for themselves based on their perception of the practices of migration management at the border. The dilemma faced by Khawla illustrates this tension. Khawla, who used to be a teacher, fled the war in Yemen and reached Melilla with her two children and husband while in a state of advanced pregnancy. The medical personnel suspected that she might be eight months pregnant and informed her that if this were the case, she would have to give birth in the enclave even though her family had already been granted the police authorisation needed to transfer to mainland Spain. She was given an appointment in the hospital planned for a few weeks later, yet the longer she waited the higher the risk she would have to stay in the enclave and thus in the Centre, facing material conditions all pregnant women in the Centre deplored. She felt anxious her family would not be able to leave because of the pregnancy and she feared the administrative/medical decision. Women's reproductive lives at the border were caught up in the broader geopolitical situation of the Spanish enclave as a sort of

antechamber to Europe (Sahraoui, 2019). Being made to wait, confined in a borderland, represents a tool of migration deterrence (Andersson, 2014) and women are particularly easily subjected to long periods of waiting when pregnant or accompanied by infants.

The entanglement of medical humanitarianism with administrative management of people's mobility turns care into an instrument of border management with important gendered implications leading to women patients fearing the medical personnel's power to care. The embeddedness of medical humanitarianism within border management exacerbates the power hierarchies that medical interactions entail and by doing so transform the meanings of care. 'In caring and protecting, humanitarian action simultaneously intervenes in and stops mobility in rather problematic ways', as noted by Beste Isleyen (2018: 853) in her study of humanitarianism at Turkish borders. Women's experiences in the Southern Spanish enclave of Melilla equally shed light on the uneasy relation between humanitarian medical assistance, migration control and mobility. Control over spatial mobility through maternity care reveals the gendered dimensions of the previously studied 'geographies of humanitarianism' (Pallister-Wilkins, 2018b). The caring function of the humanitarian border is not only enmeshed in the objective of migration control, but it also responds to this very purpose. In her Australian research, Kirsten Phillips (2009) argued that those pertaining to the 'women and children' category 'may live only in spaces where a sovereign authority directly and intimately manages life according to biopolitical imperatives' (133). Concurring with her reading and in the context of humanitarians' medical decisions having direct implications for migrants' mobility in Melilla, women's reproductive health becomes yet another dimension to keep under control as their bodies come to pertain to the gendered biopolitical management of the border.

The fear expressed by women as to the impact of their pregnancy on administrative procedures and their leaving the enclave was not without grounds: their medical situation was communicated to the Centre's management and did impact administrative proceedings given that after a certain stage of pregnancy, transfer to the peninsula, i.e. mainland Spain, was not allowed. The most upsetting element for pregnant women residing in the CETI was the perceived arbitrariness regarding the exact 'cut off' date after which transfer could not take place. In my own interviews with healthcare professionals, I have been given different dates as to the pregnancy month up until which pregnant women can still leave the enclave: while one nurse claimed that 'after the sixth month no pregnant woman can travel', another one mentioned seven months and the most common rule I have heard being mentioned by several administrative and healthcare workers was eight months. As also commented by Khawla, several of the pregnant women I met mentioned cases of other pregnant residents they had personally known to lament differentiated treatments, without any perceptible logic that could justify the latter in their eyes. As a result of these fears, this was one of the most frequent questions that the women I interviewed would ask me, seeking to cross-check the pieces of information they already had. Hanae, a 30-year-old Algerian woman who had given birth 1.5 months earlier deplored:

'We don't know anything, we're always lost, no one gives us information, really, for us to feel at ease, black or white. They mix everything, they leave you like this, you always fear, you're always worried'.

The border context exacerbated the power relationships that play out in any medical interaction. Due to the accumulation of material, legal and linguistic vulnerabilities, migrant women residing in the CETI found themselves in a very precarious position within the medical encounter. In this context, healthcare professionals came to exercise power over

these women's lives beyond strictly health-related issues due to the inscription of medical practices within administrative logics pertaining to border management. Healthcare professionals could indeed exert a decision-making power over migrants' mobility on the basis of their medical authority. Mona, a healthcare professional consulting in the Centre, recounted for instance the case of a family whose transfer was postponed because a new-born was not gaining weight sufficiently:

We had some women who did not attend well the baby and it didn't take on weight normally. So we had to see her everyday because they didn't know how to take care of the baby, until it gained weight, until the baby reached a certain weight, until then you can't be authorised to travel. [...] When you see that the baby is well then I say "yes, she can be authorised to travel" but otherwise if I see that the baby is not well then they stay here I say "no, until it weighs six kilos".

Again, the doctor's expert knowledge expressed here cannot be detached from the border context in which it is stated. Researching the role of Doctors Without Borders (MSF) in delivering medical and non-medical assistance along the Eastern Mediterranean Route and through the Balkans, Polly Pallister-Wilkins (2018a) came to the conclusion that 'mobility remains in tension with humanitarian practice, especially of the medical kind, which requires fixed spaces and sufficient time for effective, adequate and ethically sound treatment to be carried out' (134). The Melilla case on the Western Mediterranean route further demonstrates that migration control produces practices of immobilisation in the name of care. Yet, against the background of the geopolitical role of the Spanish enclaves as a waiting room to Europe, these practices of immobilisation went against what the women aspired to most, i.e. continuing their migration journey. Immobilisation for medical reasons in material conditions of life that were supposed to remain temporary, that most women deplored and that were allegedly better once in mainland Spain, felt strangely paradoxical. In the above-mentioned example, once the police authorisation had been granted, the doctor ultimately decided when the family would be able to travel. Given that medical and administrative reasons worked hand in hand, the information was transmitted to the administration that established the list of individuals that were transferred to the peninsula.<sup>3</sup> Thus, patients did not have the possibility to make use of their medical information as they wished, rather, healthcare professionals' advice acquired police-like authority. From the battery of medical examinations administered upon entry to practices of immobilisation in the name of care, the imperative of biopolitical border management fosters forms of selective care, whereby those with the power to save lives determine what aspects of migrants' existence deserve to be cared for and how. The following section grapples with the discursive frames of undeservingness that underpin medical humanitarians' claim to take up biopolitical responsibility for pregnant women and their unborn children.

### **Framing gendered and racialised undeservingness, claiming humanitarian responsibility**

The notion of deservingness is helpful to unpack how, in concrete interactions, medical personnel's authority is framed and acted upon. Sarah Willen and Jennifer Cook (2016) have conceptualised the notion of a health-related deservingness that they construe as 'the flip-side of rights' (96) since they are '*vernacular* expressions of value as opposed to juridical notions of right' (emphasis in original, 113). Importantly, they identified five themes that shape these vernacular expressions of value: '*migration motive, legal status, moral character,*

*vulnerability* and *social proximity* to members of the broader society' (emphasis in original, 103). In the humanitarian context, being considered as deserving of care implies answering to the ideal figure of the absolute victim. When I asked Hanae, quoted above, how would the healthcare she used to access in Algeria and the healthcare she accessed in Melilla compare, she answered:

'In Algeria it's normal, the communication goes well, they explain well. Here you need to insist, you need to arouse pity, they treat you . . . in Algeria with your money you do as you please'.

The healthcare Hanae had access to in the Spanish enclave, provided for primary care by humanitarians in the Centre itself and for specialist care in the hospital, was entirely for free. Yet, in the humanitarian setting, it entailed expectations as to the attitudes of migrant patients. Residents in the CETI could access primary care because they were destitute, and their attitudes needed to reflect this position, to 'arouse pity' as Hanae put it, for the humanitarian provision of care to unfold smoothly. Others have indeed argued in relation to the formation of deservingness judgements that the less individuals or groups are deemed in control of the situation they are in, the more likely they are to be perceived as deserving of assistance (Jensen and Petersen, 2017; Laenen et al., 2019; Spencer, 2016). Agency, or better said perceptions around agency, are thus central in the formation of deservingness judgements. As gender plays out heavily within perceptions around agency, with men constructed as agents of mobility and women perceived as passive followers, stereotypical representations fabricate gendered understandings of deservingness (Malakasis and Sahraoui, 2020) that feed in turn into gendered geographies of power (Mahler and Pessar, 2001). Women in the Centre were all the more expected to display gratitude that their subaltern position as alleged non-agents supposed a greater reliance on humanitarian assistance.

The perceived lack of 'social proximity' healthcare professionals expressed vis-à-vis Syrian patients further sustained a sense of responsibility for imposing specific socio-medical norms onto mothers and babies. Jamila, a nurse, resorted to an educational tone when she described the care provided to recent mothers:

Syrians don't think that babies need to be bathed every day. What is more, they say they'll get sick. We explain them that no, that it needs to be done, but these are traditions, and traditions are tough to change.

If non-compliance in a care relationship is usually frowned upon by healthcare professionals, here the specific power relationships forged by the border management context re-defined the implications of healthcare professionals' medical injunctions. The compliance/non-compliance practices by migrants, and above all the perceptions of these practices by healthcare professionals, fed into broader hierarchies of deservingness either sustaining or contradicting the figure of the good and disciplined migrant. This structure of relations resembles the one encountered by Sharon Pickering (2014) in her research with Australian maritime enforcement officers in charge of both interception and rescue: 'there was a clear perception of the genuine refugee as quiet and obedient, and the demanding refugee as difficult to manage and burdensome' (197).

The educational overtones of the humanitarian care provided to migrants produced two figures: the responsible healthcare professional, who possessed the legitimate knowledge, and in case of non-compliance or verbalised wish not to comply, the undisciplined migrant, and more specifically 'irresponsible mother', a figure that combined normative assumptions about the expected attitude of non-citizens and of women. It is the 'moral character'

dimension of Willen and Cook's conceptualisation of deservingness that was being assessed by healthcare professionals in this context. Compliance was framed as an act owed to healthcare professionals, and to the Centre's employees more broadly, due to migrants' material vulnerability, need for care and dependence upon the hosting structure. The material dimension played a significant role in shaping these power relationships and added to the complexity of the medical/administrative entanglements. Practices around breastfeeding constitute a revealing example. Lila, a nurse at the NGO, insisted:

We encourage breastfeeding after delivery, it's explained to them that it's better for the baby because many come, they're very tired, it's normal, they want powdered milk for the babies but we explain them that it's better the milk that they can give them, that it benefits themselves as well as the baby. [...] Little by little we get there.

While medical knowledge in the fields of obstetrics and maternity care yields socio-medical norms for all women to conform to (Coxon et al., 2014), these norms bore specific implications for women during lengthy migration journeys that became more characterised by immobility than mobility. Breastfeeding is strongly encouraged by healthcare professionals, yet the material conditions of living in the Centre turned this piece of medical advice into a constraint. Several of the interviewed women shared a feeling of powerlessness: tired and not feeling they were fed well enough to breastfeed, most of them wished to complement breastfeeding with formula milk. In most cases, however, healthcare professionals deemed their health state good enough not to be given any formula milk. Sanae, a 20-year-old Algerian woman, gave birth to her daughter two and a half months before we met; an Algerian friend of hers commented while the three of us were chatting:

She was breastfeeding because they didn't want to give formula milk, they said no. After they noticed that she had lost too much weight, was too tired, after 2 months they gave milk with vitamins to the daughter, once a day, a supplement, that's it.

Since most mothers could not buy formula milk themselves, nor did they have the material conditions to prepare it adequately without access to a kitchen, rather than remaining a piece of medical advice, breastfeeding became an imposed practice. Women residing in the Centre needed to comply with humanitarians' medical priorities while their own perceptions of needs at this specific stage of their migration journey differed significantly. Given that women residents were not perceived as autonomous agents, their will to access formula milk was not understood as an individual decision taken in the context of exceptional circumstances. Rather, it was accounted for within a patronising account of them not knowing what was best for the baby. Undermining women's authority over their babies' nutrition, by discarding their assessment of their own health state, is but one example of how the biopolitical drive of humanitarianism can work against women. These care interactions bring to the fore that care is not an abstract construction but an embodied experience, inscribed into a local ecology that mediates the meanings of care (Das and Das, 2006).

Embracing the same logic, the administrative supervision of the healthcare trajectory by the management of the Centre entailed taking responsibility for residents' medical files. The humanitarian responsibility to care seems to have entailed a patronising appropriation of residents/patients' medical documents. Amal, a 22-year-old Algerian woman, in her ninth month of pregnancy, recounted an instance in which she had to fight to be given medical documents that concerned her:

Last time I had a problem here in the Centre with a Moroccan [woman], she hit me in the belly, and they've sent me to the hospital by cab, I couldn't explain my situation to the doctor. The translator joined me later, I asked the doctor for a medical certificate, the translator says no to the doctor, she took the certificate . . . "why a certificate? It's not important for you." She took it and we went back to the Centre separately. After that I went to talk with the nurses: "give me my certificate or I file a complaint with the police", they made a photocopy and they gave me the original copy.

Claiming such responsibility in practice further blurred the distinction between the Centre's administration and the NGO. In Amal's perception, her medical documents were unjustly confiscated while she was unable to make her voice heard in her interaction with the doctor because of the language barrier. This situation illustrates how the specific institutional configuration of the CETI, by exacerbating the inequality of power underpinning relations between healthcare professionals and patients, further disempowered women's position in care settings. In particular, a gendered form of othering sustained judgements as to Syrian mothers' alleged lack of preparedness to fulfil mothering roles, a healthcare professional lamented:

There's still a lot of social work to carry out with the women, above all women with very little knowledge. They need to be closely attended because they're very young when they start, they have a very low level, little preparation to be a mother.

Stigmatising representations of migrant women's reproductive and mothering choices are documented by several case studies that concur in their analysis of othering processes that sustain the depiction of migrant women's reproductive lives as irrational and potentially threatening (Chavez, 2007; White and Gilmartin, 2008). In the context of humanitarian perinatal care, the salience of deservingness manifested itself through gendered and racialised understandings of the overlapping figures of the 'deserving/undeserving' migrant and the 'responsible/irresponsible' mother. These constructions were performative in that they influenced medical personnel's practices inscribed within the workings of migration management at the border. Mobility was framed as a risk in the context of pregnancy: Pregnant women who insisted on being authorised on the boat were described by one nurse as willing to take unnecessary risks and as putting the baby in danger for the sake of migration. In this configuration, the healthcare professional is self-represented as the responsible agent, protecting the baby to come from the risks that the mother is willing to take:

Because what we would do is to put the baby in danger, even though there are many mothers who prefer to take that risk and leave, but we won't put them on a boat for eight hours [sic, the crossing lasts about 6 hours], something could happen.

Patricia, a social worker, presents herself and her colleagues as taking up the responsibility of protecting the unborn babies, against the mothers' wishes to continue their migratory journeys. This instance illustrates how the 'liberal will-to-care' (Reid-Henry, 2014) at the core of western humanitarianism strips the recipient of that care of any agency. These care interactions demonstrate that when relations of power are too strong, here due to the enhanced authority of healthcare professionals vis-à-vis non-citizen patients, neither the logic of choice nor the logic of care can thrive, i.e. neither patients' autonomous choice nor a collective support and participation in the decision-making process (Mol, 2008). The power asymmetry that characterises care relationships in general, and obstetric care in particular as put forward by feminist scholarship, extends here to the control of the mobility of women's bodies. Other elements of these women's lives fail to be taken into consideration



and the biopolitical drive to control the biological life of these fetuses takes precedence. Immobilisation is the preferred option within a system of border management, one that seemingly offers a continuity of care and thus the fulfilment of the humanitarian responsibility taken up by these professionals. Yet, once prevented from travelling to mainland Spain, pregnant women had to give birth in Melilla and wait for a minimum period of 40 days to complete administrative procedures that would allow them to leave the enclave. This delay could last longer, mostly according to the woman's nationality. The material conditions in the Centre were not adequate to host families or single mothers with their newborns. With up to eight women per room and at times several children sleeping in their mothers' single beds, the living conditions were conducive to exacerbating everyone's tiredness and anxiety. Healthcare professionals needed to discard these elements to justify their practices and to question instead the women's sense of responsibility for being willing to spend several hours on a boat. The ways in which these women were deprived of agency, through the operation of migration control but in the name of care, remind us the importance of feminist geography's commitment to unpack the workings of power in their varied manifestations, including particularly invisibilised forms of oppressions as gendered ones tend to be. Jennifer Hyndman (2019) stated this clearly when she advocated for 'a thoroughly feminist and anti-racist political geography that does not succumb to Orientalist rescue narratives or produce regimes of care and security that subjectify refugees' (4). Practices by health professionals at the humanitarian border demonstrated in this regard how care tend to be imbued with the racialised and gendered workings of power.

## Conclusion

Contributing to a feminist geography of borders, this case-study of medical humanitarianism in the Southern Spanish enclave of Melilla sheds light on the forms of gendered domination that the care function of the humanitarian border entails. Beyond a focus on the display of securitisation that militarised borders represent, interrogating the everyday provision of medical care revealed the subtler forms of gendered control enacted by the humanitarian border. In continuation of a growing interest in the scale of the body by feminist geographers, I sought to uncover the power relations that migrant women's embodied experiences recounted within the local configuration of migration control in Melilla through an attention to their care interactions during times of pregnancy and motherhood. Drawing on the narratives of healthcare professionals working in a humanitarian setting and on the narrated experiences of migrant women residing in the CETI, as well as the observation of daily life in the Centre, the article explored how medical humanitarians came to exercise various types of power over women in their position as both migrants and patients.

The ambiguity of medical humanitarianism in the border context appeared in several instances. First, the use of the 'administrative reason' to bring migrants to agree to the mandatory medical examinations, resulting from the entanglement of administrative and medical registration procedures for entering the CETI, revealed the risk of coerced care fostered by the biopolitical governance of the border. Second, the immobilisation of women in the name of care, for reasons related to their reproductive lives, exposed some of the ways in which the care/control nexus is intrinsically gendered. If women, as in other humanitarian situations, are subject to greater levels of intervention owing to perceptions of women's vulnerability and lesser agency, the authority vested in healthcare professionals by the border enforcement context resulted in specific forms of control over women's mobility. And third, the humanitarian claim of biopolitical responsibility for migrant women and their unborn children appeared to rely on gendered and racialised accounts of migrant

women's lesser capability to decide how to care for their babies, whereby failure to comply with medical and nursing instructions entailed the risk of being read as both an undeserving migrant and an irresponsible mother.

The article foregrounded some of the ways in which medical humanitarianism, when articulated to the management of migration at the border, produced gendered constraints that impacted women's bodily experiences, from the question of consenting to certain medical examinations, to being immobilised for medical reasons, to imposed practices of mothering. The entanglement of administrative and medical procedures engendered forms of selective care that often contradicted women's perceptions of their own care needs.

On a final note, the themes scrutinised in this article aimed at contributing to the critical discussion around European border management and the growing role of humanitarian actors in this context, beyond a focus on humanitarians' individual intentions (see Huschke, 2014; Ticktin, 2011b). While I have demonstrated that the care function of the humanitarian border hinges upon unequal relations and reproduces forms of gendered domination, this context does not exhaust possibilities for genuine relations of care. Obviously, healthcare professionals' discourses and practices within the Centre entailed at the individual level well-meaning gestures of care as well as displays of empathy and attachment. To illustrate this point, I quote the words of Aurora, an administrative officer, who displayed empathy by imagining herself and her family in the life circumstances of the persons she was working with every day:

Better that they don't remember too much from the CETI, I mean, that they remember yes, but it's not a place . . . if you don't have anything else . . . but it's not an ideal place to stay for longer. It's not made for this, if I imagine myself here with my family, I would die. Going from having had a normal life in your home, in your city, and all of a sudden to be put here, with your children, eating in the canteen, breakfast, lunch and dinner, every day. So, remember, remember us, but only what is right, nothing more.

And some did remember, sending pictures once they arrived in mainland Spain to the nurse they befriended in the Centre, and keeping in touch at times months after their departure. A few were also able to access nurses' offices just to talk and take some of the daily pressure of living in the Centre off by building privileged relations. An elderly Algerian woman was for instance coming to chat almost daily with one of the nurses during the morning breaks. Although the structural power relations that the border regime exacerbated could never be fully escaped, not all aspects of the care relations equally reflected them. Beyond this caveat, what the analysis in this article aimed to achieve is to further our understanding of women's embodied experiences of the humanitarian border and of the specific patterns of domination they face.

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## Notes

1. The capitalisation of EUropean highlights the political construction of the space I refer to, i.e. borders of the European Union without merging European spaces with EUropean spatiality (Bialasiewicz et al., 2013).
2. Yet Netz (2004) does not analyse the latter case as his study ends with the Nazi camps.
3. At the time of fieldwork, transfers took place every week but they had previously been organised at different frequencies according to the occupancy rate of the Centre.

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