Perceptions and Practices of Nurses with Respect to Asylum-Seekers and Refugees Accessing Health Care Services In Musina, Limpopo, South Africa

By

TAURAI NDEMERE
NDMTAU001
Supervisor: Associate Prof Christopher Colvin

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DECLARATION

I, Taurai Ndemere declare that this dissertation is an outcome of my own research and all the sources utilised have been acknowledged by means of complete references.

I hereby declare that this dissertation is not submitted for any other degree.

Signed by candidate

Taurai Ndemere
9 February, 2020

ABSTRACT

To achieve the goal of universal health coverage, no one should be left behind. To achieve this goal, refugees and asylum seekers should be prioritised due to their heightened risks. This would improve health outcomes and assist in attaining the Sustainable Development Goals (SDGs) of 2030. In the South African context, numerous studies have been conducted on access to health care services from asylum-seekers and refugees' perspectives. It is a complicated problem, however, both the service providers' point of view and that of the patient need to be explored and understood deeply for effective action to be taken. A lack of studies from the service providers (professional and enrolled nurses) lens on asylum-seekers and refugees accessing healthcare services, specifically in Musina, Limpopo, South Africa, motivated this study. The study aimed at providing more information on the perceptions and practices of nurses on asylum-seekers and refugees accessing health care services. A qualitative approach was utilised to explore the perceptions and practices of nurses with regards to asylum-seekers and refugees accessing healthcare services. The study was conducted at Nancefield clinic and the Musina hospital in Musina with professional nurses. Semi-structured interviews were utilised to collect data and a thematic analysis approach was utilised to analyse the data. The study provided some insight on the perceptions and practices of healthcare providers. Due to the small sample size, it cannot be concluded that there is no systematic discrimination of asylum-seekers and refugees in South Africa. Nurses were incorrectly classifying asylum-seekers and refugees as economic migrants. Most nurses were of the view that the majority of their patients were migrants, including asylum-seekers and refugees. Nurses said that they apply the law in their practices as expected. Nurses believe in work documents and the hierarchy of power. These two factors guide nurses when interacting with asylum-seekers and refugees accessing their services. The study recommends that stakeholders that are working with refugees and asylum-seekers conduct capacity-building activities with nurses to raise awareness on the relationship between migration and health or government requests training.

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LIST OF ACRONYMS

ACMS	African Centre for Migration and Society
ART	Anti-Retroviral Treatment
CSVR	Centre for the Study of Violence and Reconciliation
HIV	Human Immunodeficiency Virus
HREC	Human Research Ethics Committee
ID	Identity Document
IOM	International Organisation of Migration
MSF	Medicins sans Frontiers/ Doctors without Boarders
SADC	Southern African Development Community
SGDs	Sustainable Development Goals
SLB	Street Level Bureaucracy
UCT	University of Cape Town
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

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PART A: RESEARCH PROTOCOL

BACKGROUND

The issue of migration and health is receiving more recognition as a global health priority, as well as a determinant of health (International Organisation for Migration [*IOM*], 2017). Conversely, "the relationship between migration and health remains poorly understood and action on migration and health remains limited, negatively affecting not only those who migrate but also sending, receiving, and left-behind communities" (Wickramage, et al. 2016:8). In most nations, equal access to health services is measured as a goal only in relation to citizens (Wickramage, et al. 2018). In this context, access to health services represent a critical test of the relationship between patients and the health care system (Penchansky & Thomas, 1981). Penchansky and Thomas (1981) divided accessibility to health services into four overlapping dimensions namely, physical accessibility, economic accessibility, non-discrimination and information accessibility. Accessibility and acceptability are both integral to this study. Acceptability refers, "to cultural access and relates to the interaction between the service providers and the users of the healthcare facilities" (Moyo, 2010:30). This study seeks to explore the extent of perceptions and practices of nurses in curtailing or providing an enabling environment for asylum-seekers and refugees accessing health care services.

The supreme law of the land, the Constitution of South Africa categorically states that no person can be denied emergency treatment (South Africa Constitution, 1996). Furthermore, pregnant women and children under the age of six receive free primary health care services at public health facilities (National Health Act, 2003). The Refugee Act reiterates that all refugees and asylum-seekers with a valid permit will be entitled to the same basic health services as citizens at public health facilities in South Africa (UNHCR, 2018). An asylum seeker is a refugee in waiting and a refugee is a person receiving international protection due to their, "race, religion, nationality, political opinion or membership of a particular social group" (UNHCR, 2017).

In 2007, the National Department of Health issued a directive stating, "refugees and asylum-seekers with and without a permit shall be assessed at the health facilities by the means test to access basic health care and treatment for HIV" (National Department of Health, 2007:1). A means test is used to evaluate their socio-economic status. Therefore, refugees and asylum-seekers need to get the same assistance and pay the same fees as citizens in similar social and economic circumstances.

In spite of having clear provisions in law and policy, asylum-seekers and refugees are still not reliably able to access essential health services (Human Rights Watch, 2009b). According to a study conducted by the Forced Migration Studies Programme at the University of Witwatersrand (2008), asylum-seekers and refugees face significant barriers to access health care services (Vearey, 2008, IOM, 2010 & UNHCR South Africa, 2016). "Some of the barriers include being illegally denied anti-retroviral treatment (ART) for not having South African Identity documents, being charged extralegal and prohibitive user fees, being verbally abused by health care workers, and communication barriers due to language differences" (Vearey, 2008 & UNHCR South Africa, 2016). These barriers are exacerbated by the ways policies and directives are being communicated to 'street-level bureaucrats' in the health system. Street-level bureaucrats are frontline workers who represent the state in the implementation of policies and interaction with the public (Rynbrandt, 2005; Dunsire, 1978). In this study, nurses represent street-level bureaucrats who render health care services to the public on behalf of the government. The use of the concept will assist in exploring the perceptions and practices of nurses with respect to asylum-seekers and refugees accessing health services in public facilities.

Another example of how barriers are exacerbated by how policies and directives are communicated is when the National Department of Health circulated a directive (Anti-Retroviral Treatment access to all), "without any increase in funding, training or specific regulations to guide facilities in complying with it" (Human Rights Watch, 2009b). As a result, public hospital compliance became uneven and resulted in practices that negated asylum-seekers and refugees access to health care services (Treatment Action Campaign, 2008). Policies became merely paper-based ideals without a government implementation strategy and without any urgent action to end biased practices against asylum-seekers and refugees.

There is a negative attitude from many healthcare providers towards asylum-seekers and refugees due to overburdening of the staff, lack of material and human resources (Moyo, 2010), and a perception that within a limited resource setting, citizens should be given priority (Vearey & Richter, 2008). This perception and practice set an unfortunate precedent for the whole health system. Clearly, the problems concerning access to health services of asylum-seekers and refugees are complex and politicized (Ullmann, et al., 2011; Lassetter & Callister, 2009). Addressing and understanding this phenomenon of access to health care services among asylum-seekers and refugees requires better understanding of the 'street-level bureaucrats' perspectives of the issue of access for this community. There is very little knowledge, specifically of their perceptions and practices. This study seeks to explore the perceptions and

practices of nurses with respect to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa.

PROBLEM STATEMENT

Empirical evidence shows that nurses' perceptions and practices play a pivotal role in health care delivery to asylum-seekers and refugees. "Prejudice and discrimination towards asylum-seekers and refugees still persists within the public health system despite the presence of legislative and policy documents" (South African Constitution 1996, Refugee Act 1998, National Health Act 2003). Asylum-seekers and refugees still face challenges in the South African public health sector when trying to access healthcare services (ACMS, University of Witwatersrand & CSVR, 2011) as some nurses still demand identity documents (IDs) as a requirement for treatment (Save the Children South Africa, 2018). This issue is still dominating high-level policy dialogues (Migration Policy Debates, 2018) and getting priority in research institutions such as the African Centre for Migration and Society (ACMS) in Johannesburg, South Africa.

Several studies on access to healthcare services in South Africa have been conducted from the asylum-seeker and refugee lens with very little knowledge on the perceptions and practices of nurses in relation to asylum-seekers and refugees accessing health services in South Africa (WHO and World Bank, 2017; Almeida et al. 2013). Considering the complexity and multidimensional nature of the problem, both the service providers' and patients' point of view need to be understood for effective action to be taken (Ullman, et al., 2011; Lassetter & Callister, 2009).

A lack of studies from the service providers (nurses) lens on asylum-seekers and refugees accessing healthcare services, specifically in Musina, Limpopo, South Africa, motivates this study. This study will help in providing more information on the perceptions and practices of nurses on asylum-seekers and refugees accessing health care services. Furthermore, this study would support policy makers in strengthening the health system of South Africa. It will also assist the health system in reflecting on its effort in achieving national and international commitments such as universal health coverage.

RESEARCH QUESTION

Main Research Question

What are the perceptions and practices of nurses with respect to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa?

Subsidiary Questions

1. How do nurses perceive asylum-seekers and refugees accessing health care services?

2. Do nurses understand the obligation of the health services providers towards asylum-seekers and refugees?

3. What factors inform nurse's decisions to provide or withhold health care services to asylum-seekers and refugees, or otherwise treat them differently or inequitably?

4. Does the nationality, gender, health condition, language, or any other aspects of the asylum-seeker and refugee identity influence the perspectives and practices of nurses?

THEORETICAL FRAMEWORK

Street-level bureaucracy (SLB) theory will be used to frame the study and evaluate its findings. "Street-level bureaucracies are public agencies such as police, schools and health departments who are in direct contact with the public and have wide discretion over the dispensation of public services" (Lipsky, 1980:15). The SLBs represent the government in the implementation of policies and its interaction with the public (Rynbrandt, 2005; Dunsire, 1978). SLB refers to lower tiers of the state and its engagement with the public.

According to the street-level bureaucracy theory, frontline providers employ certain practices to cope with their day-to-day stress. Some of the practices are informed by perceptions of nurses towards asylum-seekers and refugees and work conditions.

According to Walker and Gilson (2004:17), "the gap that exists between policy objectives and policy outcomes is a demonstration of how policies are reconstructed through the process of implementation, rather than implementation failure". The above statement shows that there is a "disjuncture" between what top management prescribes through policies & directives and what eventually happens at the street level. For instance, the issuance of a directive by the National Department of Health in 2007 without clarity around implementation processes created a gap that turned street-level bureaucrats into key decision makers (Moyo, 2010). Clearly, some of the decisions that are made under such circumstances are biased because are informed by attitudes, practices, and contexts in which they are implemented at a particular point in time (Moyo, 2010).

In this study, nurses will be viewed as street-level bureaucrats to try to understand their perceptions and practices in relation to who to give or deny treatment.

METHODOLOGY

Study Design: Exploratory Case Study

A case study is defined as, "a research strategy which is used to examine one or more instances of phenomena in certain settings" (Yin, 2003:34). It is also described as an empirical investigation that examines a contemporary phenomenon comprehensively and within its real-life context, especially when the boundaries that exist between phenomenon and context are not clearly evident (Yin, 2003). "The essence of a case is to try to illuminate a decision or set of decisions; why they were taken, how they were implemented, and with what result" (Schramm, 1971).

Yin (2003) divided case studies into three categories namely; exploratory, descriptive and explanatory. To choose the best type of a case study one needs to look at the type of a research question posed. When the research question focuses on 'how?' and 'why'? questions, an explanatory case study design is used. 'Who?' and 'Where'? questions suit a descriptive case study and the 'What?' questions are better answered in the exploratory case study. However, these terms do not clarify the boundaries and overlaps that exist between the case study designs. Although each case study has its own distinctive traits, there can also be significant overlaps between them (Yin, 2003). The aim is to avoid gross misfits.

Broadly, the research question posed in this study seeks to answer the 'What?' question. What are the perceptions and practices of nurses with respect to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa? The exploratory case study is therefore the most appropriate overall design for this study. Although there is an embedded "'Why?' question in the sub-questions of the study – why do nurses provide or withhold treatment – this does not imply that the use of full explanatory case study design is required.

In this study, the exploratory case study overlaps with the explanatory case study approach but the overall approach will remain exploratory. The exploratory case study is recommended specifically when very little research has been done on an issue (Mayer & Greenwood, 1980). Therefore, the use of an exploratory approach in this research is well justified.

STUDY POPULATION AND RECRUITMENT

Study Population

Population is defined as, "a term that sets boundaries on the study units. It refers to individuals in the universe who possess specific characteristics" (Neuman, 2011:241). The researcher's population will be nurses working at Nancefield clinic and Musina hospital located in Musina town. "Musina is a small town located on the Northern border of South Africa in Limpopo Province. The town of Musina is approximately

15 km south of the Beitbridge border post which borders Zimbabwe and South Africa"(UNHCR, 2018:3). Given the proximity of this town to the border, Musina has become the primary host of asylum seekers from the North and a home to those who have no relatives inland.

Nancefield clinic is meant to be the first point of entry/primary care in the local health system. Most asylum-seekers are not familiar with the South African health system, however, and often approach Musina Hospital directly, resulting in them being sent back to the Nancefield clinic to receive treatment or a referral. Musina has two public health facilities that offer promotive, preventative, curative and rehabilitative services (Nancefield clinic and Musina hospital). Hypothetically, all asylum-seekers are meant to access healthcare services at these public health facilities.

Recruitment

"Recruitment involves defining an appropriate study population and identifying strategies for recruiting participants from this study population" (Hennink, et al., 2010). It is defined as the process of choosing individuals from your study population to participate in a research (Barbie, et al., 2008). Participants will be recruited through the relevant local gatekeeper; the Department of Health in Limpopo Province. Provincial permission for the study will be sought and once received, I will then approach nurses from both Nancefield clinic and Musina hospital who have the following characteristics (study inclusion criteria):

a. Registered as either a professional nurse or an enrolled nurse

b. Between 18 - 60 years of age

c. Have worked for three months or more at the aforementioned public health facilities

d. Have worked with asylum-seekers and refugees at the public health facilities in Musina

SAMPLING METHOD AND SAMPLE SIZE

Sampling Method

"There are two paradigms to sampling; namely probability and non-probability sampling" (de Vos et al., 2011:387). In this study, I will use the non-probability sampling, specifically, purposive sampling technique. "Purposive sampling means that the researcher selects participants who possess certain qualities" (de Vos et al., 2011:387). The selection of participants is based on the researcher's knowledge of the population, its elements and the nature of the study. Nurses from the Nancefield clinic and the Musina Hospital with identified characteristics will be study participants. The selected study participants will assist in understanding the perceptions and practices of nurses with regards to asylum-seekers and

refugees accessing healthcare services. The aim is to get a detailed insight of a certain phenomenon and the context in which that phenomenon occurs (Hennink, et al., 2010). This not only requires a small number of participants for in-depth exploration of the intervention, but also necessitates the purposive sampling of participants with specific characteristics that can best inform the research topic (Hennink, et al., 2010). "In qualitative research, participants are chosen because they have particular traits or experiences that can contribute to a greater understanding of the phenomenon being studied" (Hennink et al. 2010:7). In this study, purposive sampling will be utilised. According to Hennink et al., (2010), purposive sampling is both flexible and deliberate. It seeks to select on purpose people who are information rich and diverse. Purposive sampling criteria would ensure a diverse sample of age, gender and experience.

There is already an indirect relationship between myself and the potential study participants through the United Nations High Commissioner for Refugees (UNHCR) social assistance programme in the Limpopo province, South Africa. I work for Future Families organisation as a social worker. Asylum-seekers and refugees access the researchers' services at Future Families. The asylum-seekers and refugees also access the services of the study participants at the local clinics. Some of the study participants do know that I work for Future Families, but beyond these informal links, I do not have any working or personal relationships with the healthcare workers at these public health facilities. In my introduction to the participants, I will make it clear that this is an independent project that is not related to Future Families whatsoever.

Sample Size

"The total number of study participants in qualitative studies is often small because the depth of information and variation in experiences are of interest, so large numbers of participants are neither beneficial nor practical" (Barbie, et al., 2008:67). The sample size will be guided by the "theoretical principle of saturation" (Glaser & Strauss, 1967). Saturation is the point at which the information you collect begins to repeat itself, thus, data collection becomes redundant. Although the number of potential study participants is ultimately determined by information saturation, in reality the researcher needs to identify an initial number of study participants. In this study, a total number of 10 participants will be selected initially, five from both sites (the Nancefield clinic and the Musina hospital).

DATA COLLECTION

The study is going to utilise semi-structured interviews. Semi-structured interviews aim to understand the issue from a participant's perspective and examine the meaning of people's experiences (Greeff, 2011).

Furthermore, semi-structured interviews are very useful in gathering large amounts of data in a short amount of time and are an effective way of obtaining in-depth data (Greef, 2011). Semi-structured interviews with an interview schedule will be utilised in this research study. All interviews will be conducted when the potential participants are not busy with their core work, either during break or lunch time. Permission will be sought from their superiors. All semi-structured interviews will be conducted at the Musina hospital and the Nancefield clinic. These semi-structured interviews will be tape recorded (with the consent of the participant). The audio files will be recorded on a disc as a back-up strategy and kept in a secured filing cabinet. I will also take field notes during data collection. These field notes shall be used during the data analysis stage to supplement the recordings. English is used in all professional work settings at these facilities, for example, staff meetings, written communications, trainings, attending foreign patients. Participants should therefore be comfortable enough with English to have the interviews in English. The semi-structured interviews are expected to last 30 minutes each.

DATA ANALYSIS

"Data analysis is a process of bringing order, structure, and meaning to the data collected so that they can be synthesized, interpreted and communicated in a research report" (Marshall & Rossman 1999:148). The process can be ambiguous, messy and time-consuming, however fascinating and creative at the end (Marshal & Rossman, 1999). “In this study, data analysis shall follow the approach of thematic content analysis which is described as bringing all data together, comparing and discussing related themes and examining their relationship within individuals and between groups” (Webb & Kevern, 2008). Also, Braun and Clarke (2006) describe thematic content analysis as a process in which data is sorted, identified, analysed, and reported in data patterns called themes within a data set. “The process involves reading and re-reading through the text to identify keywords, themes, or ideas that repeat in the transcripts” (Braun & Clarke, 2006:85). In this study, the data themes will also be framed around the objectives of the study. A computer software package called Nvivo will be used to reduce manual task on the whole process of data analysis. This will assist the process of data analysis to be thorough, meticulous and transparent, enhancing rigor. I will also do ‘member checking’. Member checking can be described as taking the findings of the study back to study participants to validate the authenticity and check if the findings accurately reflect their perspectives. It confirms the participants’ viewpoints are captured and reflected appropriately. Hence, reduces biases and enhances rigor.

PILOT STUDY

Baker (2003:327) defines a pilot study as, “a procedure for testing and validating an instrument by administering it to a small group of participants from the intended test population”. The aim of the pilot

study is to improve the efficiency and effectiveness of the investigation. There should be a room for comments or criticism by the participants on the questionnaire, during the interviews or with whatever data collection method is to be used (Strydom, 2011). These comments must be carefully considered by the researcher during the main investigation. The pilot study is expected to be implemented in the same manner as planned in the main study. “In a qualitative research, the pilot study is usually informal, and few respondents possessing the same characteristics as those of the main investigation may be involved in the study, merely to ascertain trends. Its purpose is to determine whether the relevant data can be obtained from the respondents” (Strydom & Delport, 2011:394). The pilot study for this research can be defined as mainly an experiment of data collection tools, specifically the interview schedule and recorder. The pilot study will indicate if the intended tools for data collection will obtain the richest data. In this study I will conduct the pilot study with two participants of the study who will not form part of the main study. The participants will be taken from Musina hospital and Nancefield clinic since all potential study participants will be selected from these two sites. The informed consent will be explained to the participants and signed by all parties. The observed obstacles and feedback received during the pilot study will be used to prepare for the main study and ensure that a well-informed data is obtained.

TRUSTWORTHINESS

Bias and reactivity are some problems that threatens trustworthiness, to ensure trustworthiness in this study the researcher will utilise the following strategies.

Reflexivity

Lietz, et al. (2006:448) define reflexivity as "active acknowledgment by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation". “Reflexivity involves deconstructing who we are, and the ways in which our beliefs, experiences, and identity intersect with that of the participant” (Lietz, et al., 2006:448).

I am a social worker by profession. I am originally from Zimbabwe. I have never claimed asylum or refugee status in South Africa. I have been living in South Africa for more than 10 years and have never accessed public health services. I am employed in the humanitarian sector where I render social services to asylum-seekers and refugees. I have no direct contact with potential study participants. I have no power over potential study participants. The potential study participants serve the programme beneficiaries of myself indirectly. I am a person interested in improving the interactions between nurses and the asylum-seekers and refugees when accessing health services in Musina. Both myself and potential participants work with asylum-seekers and refugees almost daily. Both myself and potential study participants seek to advance

the well-being of our clients. However, this study is an independent project, unrelated to my employer. Given my concern with improving access to health services for asylum-seekers and refugees, it will be important during the interview process to try and remain as non-judgmental and as open as possible when asking nurses about the perceptions and practices with respect to this population.

Audit Trail

An audit trail is key in establishing rigor in qualitative work because it brings transparency. Lietz, et al. (2006:450) state that, “an audit trail allows a researcher the freedom to make unique research decisions not previously prescribed while still requiring that each decision and the justification for that decision be recorded along the way”. An audit trail give a researcher flexibility to follow his or her own research procedures consistently. All changes to initial procedures outlined in this study will be recorded and reported.

Triangulation

"Triangulation is an important strategy for establishing rigor in qualitative work as opposing perspectives can bring an increased understanding of the data" (Lietz, el at., 2006:451). In this study, data analysis will be triangulated through investigator triangulation. The supervisor will review the transcripts and emerging analyses and discuss emerging findings and interpretations as a way of testing and refining these findings. Member checking will also be conducted with a few of the study participants to check if emerging findings resonate with the participants. All these efforts will enhance rigor of this study.

Credibility

According to Lincoln and Guba (1986:79), credibility, deals with the question, “how congruent are the findings with reality?” In this study, to ensure credibility the researcher will do an audit trail of all the deviations from the initial plans of the study. Trustworthiness of data in this study will be enhanced through following the prescribed research design and triangulation of the data. The findings of the study shall be shared with participants to validate the authenticity of the data and also with the supervisor of the researcher. This will reduce the researcher’s bias. During recruitment, the researcher will encourage honesty from potential participants when providing data. In this study, all the potential participants will be given an opportunity to refuse to participate in the study to ensure that data collection sessions involve only those who are genuinely willing to take part and prepared to offer the richest data. All deviations taken will be documented and reported.

Confirmability

Lincoln and Guba (1986), believe objectivity in science is linked to the utilization of instruments that are not dependent on human skill and perception. “Confirmability refers to the degree to which the results could be confirmed or corroborated by others” (Lincoln & Guba, 1986:42). There is a difficulty in ensuring real objectivity, since interview schedules are designed by humans; therefore, the intrusion of the researcher's bias is inevitable. “Confirmability is the qualitative investigator’s comparable concern to objectivity” (Lincoln & Guba, 1986:42). I admit that I am a migrant and my perceptions on the phenomenon under study could be biased due to events witnessed while working with asylum-seekers and refugees. To ensure this bias is reduced, I will clarify that there is no association between the proposed research and Future Families during the introduction to the participants. I will keep the audit trail of the study. Data analysis process will also be triangulated (member checking, researcher analysis & study supervisor analysis) and descriptive and interpretive findings will be well supported by evidence from the interviews.

Transferability

“Transferability refers to the extent to which the results can be transferred to other contexts or settings” (Lincoln & Guba, 1986: 43). The study will be conducted in Musina, a small border town located in the north of South Africa in the Limpopo Province. Musina town is about 15 km south of the Beitbridge border post, which borders Zimbabwe and South Africa. Musina receives a lot of migrants coming into the country legally and illegally and most of these people access public healthcare services. In this group of migrants, I will focus on the asylum-seekers and refugees. In order to support those who may want to transfer the study findings to their own context, I will include sufficient contextual information in the analysis, allowing readers to determine how transferable the findings might be to another context.

STUDY LIMITATION

Within the setting of this research, I identify two key limitations, namely:

1. The sample size is small, therefore, findings may not reflect the full depth and diversity of perceptions and practices among the participant population.
2. I will conduct a study with participants of different cultures and backgrounds. This might influence their sharing of information because of the sensitivity of the subject.

ETHICAL CONSIDERATIONS

“The fact that human beings are the objects of study in qualitative work brings unique ethical problems to the fore for researchers in the social sciences, the ethical issues are pervasive and complex since data

should never be obtained at the expense of human beings" (Strydom, 2011:113). Also, Bulmer (1982) believes that the scientific community has an obligation not only to the principles of the search of objective truth and knowledge but also to the participants of their study. As a researcher, "one have to always take account of the effects of his actions upon the subjects and act in such a way as to preserve their rights and integrity as human beings" (Bulmer, 1982:14). In this study, the following actions shall be taken to preserve the rights and integrity of the study participants.

Informed Consent

Informed consent mean that a researcher need to make his or her aim of the study explicitly and provide a detailed explanation of the process and its effects to the participants (Strydom, 2011:117). The aim of the study will be explained to participants. All study procedures will be outlined, including expected duration of the semi-structured interview. The confidentiality aspect of the study will be discussed. Participants will be asked if they want to take part and will be provided the chance to withdraw at any time if they wish, without any consequences. The benefits of the study will be discussed though there are direct benefits to individuals who participate, along with the risks of the study. After explaining everything, I will ask the participant if they understand everything, if they have any questions, and if not, whether they consent to participate. If they do, they will be asked to sign the informed consent letter.

Privacy/Anonymity/Confidentiality

In this context, "privacy implies the element of personal privacy; confidentiality indicates the handling of information in a confidential manner whilst anonymity refers to the privacy of the subject" Strydom (2011:119). Strydom (2011:119) write that "it is imperative that researchers be reminded of the importance of safeguarding the privacy and identity of respondents, and to act with the necessary sensitivity where the privacy of subjects is relevant". In this study, I will not use participants' actual names in collecting and managing data to ensure the identities of the participants are concealed. To ensure privacy, I will explain to the participants that the information shall be used for academic purposes and my supervisor shall examine the information but will not know their real names. To ensure confidentiality, I will explain that the information will be kept securely by the University of Cape Town in line with its policies that allow me to keep data on UCT cloud-based storage options like Microsoft OneDrive. I will be able to secure access to this data from anywhere, but only by using UCT credentials.

Voluntary Participation/Ability to Withdraw

In this study, participation will be voluntary and participants will be able to withdraw from the study at any stage of the interview. They will be no consequences for withdrawing from the study. This will be explained in detail before allowing participants to sign the informed consent form.

Deception of Participants

According to Struwig & Stead (as cited in Strydom, 2011:118) deception refers "to misleading participants, deliberately misrepresenting facts or withholding information from participants". In this study, I do not plan to be deceptive to get data. I will provide the goals, objectives and background of the study and clearly explain what the expectations of the study will be without deceiving the participants.

Benefits

The study would be used to motivate for capacity building activities of nurses working directly with asylum seekers and refugees and directly enhance accessibility of health services by this vulnerable group.

Risks

There is minimum risk to participants associated with the study. Sharing of your perceptions and experiences can trigger emotions that could cause discomfort. If there is any discomfort caused by the study, participants will be referred to a counselor for counselling services at Future Families Organisation. Future Families renders free psychosocial services to professionals and individuals in Musina.

TIMELINE FOR THE PROPOSED STUDY

Table 1. Timeline for the study

Task description	Time
UCT HREC ethics application	August 2019
UCT HREC ethics approval	October 2019
Limpopo Health Department ethics application	November 2019
Limpopo Health Department ethics approval	December 2019
Data collection and analysis	December 2019
Data analysis	December 2019 – January 2020
Write-up and dissemination	January –February 2020

BUDGET FOR THE PROPOSED STUDY

Table 2. Budget for the study

Item	Cost per unity	Number of Units	Total
Researcher's time	--	--	-- v
Transcription services (interviews)	R5/minute	300 minutes	R1500-00
Printing	R1.00/ page	110	R110-00
Recording devices	R1000/unit	1	R1000-00
Language editor	R70/page	70	R5200-00
Total	--	--	R7810-00

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PART B: LITERATURE REVIEW

Migration and health: A global overview

Migration has become a defining and contentious issue of our generation and has precipitated a crisis in many of our democracies (IOM 2018). Migrants are present in all countries in the world. In 2019, their number surpassed 272 million, which equals 3.5 per cent of the global population (UN IOM Migration World Report, 2020). Migration is defined as the movement of people away from one geographical unit to another across a political or an administrative border, for a short or long-term stay (IOM, 2018; UNHCR, 2017). There are approximately 79.5 million displaced people currently in the world, including 26 million refugees, 45.7 million internally-displaced persons and 4.2 million asylum-seekers (UNHCR Global Trends, 2020). Migration is a determinant of health (WHO et al., 2016; Vearey, 2013), and if the best evidence-based research is applied, the health of the migrants, host population and those who remain behind could be improved (Abubakar et al., 2018).

Currently, two different systems are in operation, one for migration and the other for refugees. The refugee system is regulated by the 1951 Convention Relating to the Status of Refugees and mandated to United Nation High Commissioner for the Refugees (UNHCR). The migration system involves a variety of international laws, different organisations and many informal processes. According to the IOM (2018), a "migrant is someone who has moved across an international border or within her or his own country away from their habitual place of residence". Contrary to political rhetoric, most people migrate within their own countries and do not cross international borders (Abubakar et al., 2018; UNHCR, 2018; Vearey et. al., 2017). Those who migrate beyond their international borders do so for reasons related to work, family or study (Abubakar et al., 2018).

In contrast, other people leave their place of birth for a range of compelling and sometimes tragic reasons, including persecution, conflict and disaster (UN IOM Migration World Report, 2020). The 1951 Convention and its 1967 Protocol define a refugee as an individual who has fled "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable or unwilling to avail himself to the protection of that country". An asylum-seeker is someone who is waiting to be recognised as a refugee (UNHCR, 2016). Refugees and asylum-seekers are a subset of migrants and considered to be at risk and in need of international protection. They enjoy the same universal human rights and fundamental freedoms as migrants.

The toxic discourse on migration and deplorable political environments (Abubakar et. al., 2018) undermine the 2030 Agenda for Sustainable Development with its goal of "leaving no one behind", specifically in relation to universal health services. Universal health services aim to reduce disparities that create and sustain adverse health outcomes (de Gruchy & Vearey, 2016). Various international agreements were signed by member states, including the New York Declaration, the Colombo Declaration, the Global Compact on Refugees and the Global Compact for Migration, to promote the integration of migration in health planning (UN IOM Migration World Report, 2020). Negative discourse on migration and deplorable political environments often lead to migrants being labelled as "other". This implies that the rights of migrants are under attack by the same structures and processes that are supposed to protect them (Abubakar et. al., 2018).

According to Weis (1995), “othering” defines and secures one’s own identity by distancing and stigmatising the “other”. Migrants are often “othered” and experience marginalisation, disempowerment and social exclusion (Grove & Zwi, 2006). For instance, Australia creates the “otherness” of refugees and asylum seekers by maintaining distance through detention processes which separate the host population from asylum seekers and refugees (Grove & Zwi, 2006). Migrants often undertake risky journeys to reach their destinations, and as a consequence, exposure to disease and ill-health is substantial (Grove & Zwi, 2006). Instead of responding to the health needs of migrants, many receiving countries focus on controlling migration (Grove & Zwi, 2006; Abubakar et. al., 2018).

According to UNAIDS (2018), 35 countries imposed some form of travel restriction on people with HIV in 2015. Of these 35 countries, five had completely banned entry of HIV-positive people; four required people to disclose their HIV status; and 17 were deporting HIV-positive people (UNAIDS, 2018). Such actions are not allowed on the grounds of human rights and public health. These discriminatory regulations and policies undermine the migrants’ right to health on an equal basis with others (UN, 1966), since “linking health status to migration enforcement reinforces distrust of the health system and limits migrants’ ability to access health care on a discriminatory basis” (Mann et al. 1994; IOM, 2013). Migrants move with their health profiles to their destinations (Vearey, 2018) and infectious diseases can be controlled through restricting movements (Gushulak & Macpherson, 2006). Clearly, migration affects the epidemiology of the condition in the receiving community and the health outcomes of the local population. Many countries have policies and regulations that allow migrants access to health services. For example, Kenya’s constitution guarantees the right to health to everyone within its borders (Arnold

et al., 2014). Yet despite legal protection, migrants often continue facing challenges including administrative issues, cost differentials, harassment and language barriers (Arnold et al., 2014).

To ensure migration is integrated into the national systems, UNHCR has already started promoting national health systems (UNHCR, 2018). For instance, starting in 2015, UNHCR partnered with Ghana's Ministry of Health in implementing an insurance health scheme for refugees; enabled 100 000 refugees in Egypt to receive normal health services at a nominal fee in 2016; and signed an agreement with Iran to support one million Afghanistan refugees' access to health services in 2016 (UNHCR, 2018). The ideal aimed at is the establishment of equitable and non-discriminatory access to healthcare between and within populations.

Progress on realising the right to health for migrants has been slowed down by a lack of data on migration and health (IOM, 2018; Vearey et al., 2016; UN IOM Migration World Report, 2020). The relationship between migration and health is a multifaceted and complex issue. The perspectives of both health users and providers need to be thoroughly explored. Any form of discrimination and obstacles at the level of social, institutional and individual health providers needs to be recognised, confronted and avoided. For migrants, health services should be culturally and linguistically acceptable. Many studies have been conducted from health users' perspectives, but very little has been done towards understanding and reflecting on healthcare providers' perceptions and practices in order to foster non-paternalistic clinical encounters (Tervalon & Murray-Garcia, 1998). Understanding the migration-health nexus is key in making health systems responsive and putting into operation a universal health approach. This study will focus on the refugee system that is regulated by the 1951 Convention Relating to the Status of Refugees and explore the perceptions and practices of nurses with regard to asylum-seekers and refugees accessing health services in Musina, Limpopo, South Africa.

The South African public health system

South Africa has no camps for refugees and asylum-seekers. Its progressive, integrative and urban refugee policy affords refugees and asylum-seekers the freedom to self-settle and integrates (ACMS, 2011). The South African Constitution of 1996, the Refugee Act of 1988 and the National Health Act of 2003 give certain rights through protective legislation to refugees and asylum-seekers. Some of the rights include the right to employment and access to social services, including basic healthcare (Vearey, 2013). In 2007 a directive was developed to allow both refugees and asylum-seekers, with or without permits, to access free basic health services and anti-retroviral treatment (ART) (NDOH, 2007). Vearey (2008), IOM (2010), CoRMSA (2011) and Vearey (2011) have revealed that many refugees and asylum-seekers faced obstacles

when attempting to access health and other services because protective policies failed to translate into protective practices. The World Health Assembly (WHA, 2008:8) stated that "South Africa adopted Resolution 61.7 of the 61st annual World Health Assembly on the Health of Migrants, which calls on member states to promote equitable access to health promotion, disease prevention and care for migrants". Though some of the existing policies, guidelines and directives have proven to be ambiguous to health providers, refugees and asylum-seekers should always retain as much right to health as South African nationals (ACMS, 2011). This right has been reiterated by the South African Constitution of 1996, the Refugee Act of 1988 and the National Department of Health (NDOH) 2007 directive. This implies that refugees and asylum-seekers may access free primary healthcare, free anti-retroviral treatment and will be subjected to the same means tests as citizens for any higher-level care (Vearey & Nunez, 2011). Like indigent South African nationals, refugees and asylum-seekers who cannot afford to do so shall be exempted from paying fees (ACMS 2011) although some higher-level care such as the treatment of dialysis prioritises South African nationals (Chirwa, 2019:5). Healthcare providers have an important role to play in ensuring South Africa attains the 2030 SDGs by "leaving no-one behind" (de Gruchy & Vearey, 2020). These goals will be achieved through universal health coverage. As indicated by Vearey et al. (2018), public health system responses need to recognise migration as a determinant of health.

This study will be conducted in Musina, a small border town located in the north of South Africa in the Limpopo Province. Musina town is about 15 km south of the Beitbridge border post which separates Zimbabwe and South Africa. Musina receives a large number of migrants coming into the country legally and illegally and most of these people access public healthcare services. Most of them take perilous journeys to reach Musina. Within this group of migrants, I will focus on the asylum-seekers and refugees because of their heightened vulnerabilities and will explore the healthcare providers and patient interface in order to understand their interactions from the nurses' perspective, in this context. This study thus seeks to bridge the information gap that exists in understanding the perceptions and practices of nurses with regard to refugees and asylum-seekers accessing health care services in Musina, Limpopo, South Africa.

Challenges experienced by healthcare service providers working with refugees and asylum-seekers

Healthcare providers experience difficulties when providing care to refugees and asylum-seekers. Cultural and linguistic barriers rank top among the challenges between practitioners and patients (Priebe et al., 2011:13). The administrative procedures become prolonged and complicated for healthcare providers due to language barriers (Florest et al., 2002). The inability of migrants to communicate their problems

due to language difficulties poses the risk of being misunderstood and ultimately, misdiagnosed (Priebe et al., 2011). In some instances, health providers report that extensive physical examinations and diagnostic tests have to be done sometimes to compensate for the inability to communicate verbally (Priebe et al., 2011).

A lack of familiarity with the healthcare system is also a challenge among newly arrived asylum-seekers and refugees (Priebe et al., 2011). This lack of familiarity can affect the available treatment (IOM 2018:29). Health providers believe migrants' previous experience in other healthcare systems often leads migrants to have different expectations when interacting with the current health system (Priebe et al., 2011). These different understandings of the relationship may result in unpleasant encounters. Also, healthcare providers believe migrant patients have unrealistic expectations about their capacity to sort out various physical and social problems within short consultations (Florest et al., 2002).

Healthcare providers experience problems linked specifically to different understandings of the given illness of a migrant patient and the treatment options. Priebe et al. (2011) believe that "the expression of aetiology, symptoms, and pain make diagnosis difficult to establish, especially when understandings of these concepts greatly differ between the patient and practitioner". Nurses believe the challenges in treating migrant patients who have different concepts of the human body occasionally result in patients deciding not to follow the recommended treatment (WHO, 2018).

Differences in cultural norms, religious practices and customs complicate healthcare providers' capabilities during direct examination and treatment when attending to refugees and asylum-seekers (Priebe et al., 2011). Healthcare providers report concerns regarding appropriate engagement during physical examinations, which entails preserving and respecting religious restrictions on physical contact and cultural taboos (Moyo, 2010). Healthcare providers have explained that this usually results in patients refusing care or being unwilling to disclose sensitive information. Other cultural differences manifest in practical issues such as not attending appointments, turning up late, or seeking consultations outside of opening hours (WHO, 2018). Often this leads to disappointment and frustration, as patients would be asked to make another appointment resulting in general strain on time and resources (Priebe et al., 2011). Also the healthcare providers are not receiving training on migration, mobility and development when being trained at various academic institutions in South Africa (Vearey, 2013).

There is a lack of trust from some migrant patients towards healthcare providers (IOM, 2018). Distrust towards practitioners and interpreters originates from countries where refugees and asylum-seekers

previously experienced political or religious conflict and was reported in this context (Priebe et al., 2011). Some migrant patients explicitly requested to be seen by another staff member or refused to share information based on their negative attitudes towards staff or hostile behaviour, largely attributed to misunderstandings, cultural variations or the feeling of being taken for granted (Bocanegra et al., 2018:415). Priebe et al. (2011:218) state that "fear of discrimination reported by healthcare providers in explanations of patient reticence is often based on current and previous societal experiences or opinions reported in the media". However, healthcare providers' behaviour towards refugee patients could also perpetuate this fear of discrimination.

Healthcare providers complain about the lack of access to medical histories of most refugees and asylum-seekers. Priebe et al. (2011) report that if such information is available, it is usually in a foreign language. This issue causes further complications associated with their not being aware that patients have had vaccinations, allergies or previous health problems (Moyo, 2010). Also, the lack of contact details and nationality make decisions regarding consent and next of kin problematic (Priebe et al., 2011).

Although some studies have been conducted on the challenges experienced by healthcare providers interacting with refugees and asylum-seekers, little effort has been made to understand what influences healthcare providers' (nurses') interactions with migrants accessing health services. Given the proximity of Musina to the South African border, it has become the primary host of asylum-seekers from the north, and very few studies have been conducted from the healthcare providers' point of view to explore the issue of access to health services through the providers' lens (WHO and World Bank, 2017; Almeida et al., 2013). This study will assist in understanding if the challenges experienced by nurses towards asylum-seekers have a bearing on shaping their perceptions and practices when rendering services to this population.

Challenges experienced by refugees and asylum-seekers in the South African health system

Most of the literature reviewed has shown challenges experienced by refugees, asylum-seekers and migrants in general. However, most of these studies were conducted from the point of view of the patient. The South African health system is overburdened; providing adequate access to health care services to all is currently a challenge and the South African health system struggles to provide health services that are up to standard for their entire population (Adams & Rother, 2017). The UNHCR (2018) endorses this, stating that the growing number of asylum-seekers and refugees in South Africa presents enormous challenges for the local health system. Burgess (2004) believes every potential patient has potential challenges, but people of foreign-born or migrant backgrounds encounter unique barriers when

attempting to benefit from health care. The World Bank (2016) concurs that migrants are less likely than other populations to access or fully benefit from their host country's health system. This also happens in countries where legislation and policies explicitly confirm a range of rights regardless of legal status, including access to free basic healthcare, but where these rights are not always sustained (World Bank, 2016).

According to the Forced Migration Studies Programme at the University of Witwatersrand (2008), asylum-seekers and refugees face significant barriers in accessing healthcare services (Vearey, 2008; IOM, 2010; UNHCR, 2016). Some of the barriers include being illegally denied anti-retroviral treatment (ART) for not having South African identity documents, being charged extralegal and prohibitive user fees, being verbally abused by healthcare workers, and communication barriers due to language differences (Vearey, 2008; UNHCR, 2016). Based on their study in South Africa, Crush and Tawondera (2014) point out that xenophobia could also be witnessed in the public health system, which they refer to as 'medical xenophobia'. Some of the examples of medical xenophobia include hospital security denying non-nationals entry into a health facility, health professionals placing non-nationals in long queues and verbal insults (Crush & Tawondera, 2014).

Due to the lack of linguistically and culturally accessible care, refugees and asylum-seekers find it difficult to trust and respect nurses and western medicine (Burgess, 2004). "Without proper communication, medical history, current needs, personal health practices and beliefs, this population is prone to medical mistakes" (Burgess, 2004:14). These errors could involve patient-provider miscommunication resulting in possible misdiagnosis and patients' non-compliance due to incomprehension of instructions. The refugee or asylum-seeker could leave the consultation confused, possibly misdiagnosed, and with little confidence in the care provided and the health system in general (Priebe et al., 2011). As a result of this negative experience, refugees and asylum-seekers may feel alienated and resent the health system, which could act as a barrier in seeking future healthcare services (Burgess, 2004:15).

Role of international organisations and non-state actors

Within the United Nations (UN), the World Health Organisation (WHO) has a constitutional function to act as the "directing and coordinating authority on international health work" (WHO, 2018:5). WHO has the primary responsibility of promoting and achieving Health for All and universal health coverage within the context of the 2030 Agenda for Sustainable Development and its associated goals, while leaving no one behind (WHO, 2018). To attain the SDGs, the UN secretariat needs to ensure that migration and health are part of the national health systems (WHO, World Bank 2017). Member states, the International

Organisation for Migration, the United Nations High Commissioner for Refugees and other UN agencies and networks as well as other international organisations and relevant stakeholders all need to be involved in coordinating this global action plan (WHO; World Bank, 2017). Within UN agencies, the UNHCR is mandated to provide international protection to refugees and is regulated by the 1951 Convention Relating to the Status of Refugees (UNHCR 2018). During periods of displacement, it provides humanitarian assistance to refugees to meet their basic needs, including healthcare support (UNHCR, 2018:2). In South Africa, it provides these services through its implementing partners located in Gauteng, Limpopo, the Western Cape and KwaZulu-Natal. Before 2015, Medecins sans Frontier/ Doctors without borders (MSF) provided primary healthcare services to migrants in Musina. IOM South Africa also advocated for migrants in Musina. Currently, UNHCR and its partners advocate for refugees' rights and raise awareness of their issues. Little effort has been made to enhance nurses' capabilities when interacting with refugees. This study will assist in strengthening the health system to be migrant-sensitive and improve universal health coverage, thus helping to translate protective policies into protective practices and meeting local, regional and international health commitments.

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PART C: JOURNAL MANUSCRIPT

Title: Perceptions and Practices of nurses with respect to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa

ABSTRACT

Background: To achieve the goal of universal health coverage, no one should be left behind. To achieve this goal, refugees and asylum seekers should be prioritised due to their heightened risks. This could improve health outcomes and assist in attaining Sustainable Development Goals (SDGs) of 2030. In the South African context, numerous studies have been conducted on access to health care services from asylum-seekers and refugees' perspectives. Because it is a complicated problem, however, both the service providers' point of view and that of the patient needed to be explored and understood deeply for effective action to be taken. However, there was a lack of studies from the service providers' (nurses) point of view on asylum-seekers and refugees accessing healthcare services, specifically in Musina, Limpopo, South Africa.

Aim: To explore the perceptions and practices of nurses with respect to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa.

Setting: The study was conducted at the Nancefield clinic and the Musina Hospital in Musina, Limpopo, South Africa.

Methods: An exploratory qualitative approach was used, utilised semi-structured interviews to collect data and a thematic analysis approach to analyse the data.

Results: Nurses were not systematically discriminating against asylum-seekers and refugees. Most nurses were incorrectly classifying asylum-seekers and refugees as economic migrants.

Conclusion: Nurses lack knowledge of different classes of migrants. Nurses also have the view that, on a daily basis, the majority of their patients are migrants, including asylum-seekers and refugees. They feel that the health system is being overstretched without enough resources to compensate for the services rendered.

INTRODUCTION:

The issue of migration and health is receiving more recognition as a global health priority, as well as a determinant of health[1]. However, the relationship between migration and health remains poorly understood and action on migration and health remains limited, negatively affecting not only those who migrate but also sending, receiving, and left-behind communities[2]. In most nations, equal access to healthcare services is measured as a goal only in relation to citizens[2]. In this context, access to health services represent a critical test of the relationship between patients and the health care system[3]. Penchansky and Thomas[3] divided accessibility to health services into four overlapping dimensions namely, physical accessibility, economic accessibility, non-discrimination and information accessibility. Accessibility and acceptability were both integral to this study. Acceptability is described in relation to cultural access and relates to the interaction between the service providers and the users of the healthcare facilities[4].

Empirical evidence shows that nurses' perceptions and practices play a pivotal role in health care delivery to asylum-seekers and refugees. Prejudice and discrimination towards asylum-seekers and refugees still persists within the South African public health system despite the presence of progressive legislative and policy documents[5, 6, 7.] Asylum-seekers and refugees still face challenges in the South African public health sector when trying to access healthcare services[7] as some nurses still demand identity documents (IDs) as a requirement for treatment[8] . This issue is still dominating high-level policy dialogues[9] and getting priority in research institutions such as the African Centre for Migration and Society (ACMS) in Johannesburg, South Africa.

Several studies on access to healthcare services in South Africa have been conducted from the asylum-seeker and refugee lens with very little knowledge on the perceptions and practices of nurses in relation to asylum-seekers and refugees accessing health services in South Africa[10, 11]. Considering the complexity and multidimensional nature of the problem, both the service provider and patients' point of view need to be understood for effective action to be taken[12, 13]. A lack of studies from the service provider (nurse) lens on asylum-seekers and refugees accessing healthcare services, specifically in Musina, Limpopo, South Africa, motivates this study. This study will help in providing more information on the perceptions and practices of nurses on asylum-seekers and refugees accessing health care services. Furthermore, this study would support policy makers in strengthening the health system of South Africa. It will also assist the health system in reflecting on its effort in achieving national and international commitments such as

universal health coverage. The study seeks to explore perceptions and practices of nurses with regards to asylum-seekers/refugees accessing health care services in Musina, Limpopo, South Africa.

METHODOLOGY

Study design: To explore the perceptions and practices of nurses with regards to asylum-seekers and refugees accessing healthcare services, a case study was used. A qualitative design with a comprehensive thematic analysis approach assisted to explore nurses' perceptions and practices and to understand factors that shape those perceptions and development of practices.

Study population & setting: This study was conducted at the Nancefield clinic and the Musina Hospital, with professional and enrolled nurses irrespective of gender. However, since the goal was to explore the perceptions and practices of nurses with regards to asylum-seekers and refugees accessing healthcare services, the study only included nurses from 18 to 60 years of age due to retirement age limit.

Sampling and recruitment: Non-probability sampling was utilised, particularly the purposive sampling technique. Study participants were nurses registered as either a professional nurse or an enrolled nurse and aged between 18-60 years of age. Professional and enrolled nurses that worked for three months or more and have worked with asylum-seekers and refugees at Nancifield clinic and Musina hospital in Musina were eligible to participate in this study. 10 participants were recruited, 5 from each study site mentioned above. The researcher had an already indirect relationship with participants through the United Nations High Commissioner for Refugees (UNHCR) social assistance programme in Limpopo province, South Africa. The researcher worked for Future Families organisation as a social worker. Asylum-seekers and refugees accessed the researchers' services at Future Families. The asylum-seekers and refugees also accessed services of the study participants at the local clinics. Some of the study participants were not aware that the researcher was working for Future Families. Beyond those informal links, the researcher did not have any working or personal relationships with the healthcare workers at those public health facilities. In his introduction to the participants, he made it clear that this was an independent project that was not related to Future Families whatsoever (see appendix 2).

Data collection methods: This study utilised semi-structured interviews with an interview schedule. All interviews were done when the participants were not busy with their core work, and conducted either during break or lunch time. Permission was sought from participants' superiors. All semi-structured interviews were conducted at Musina hospital and Nancefield clinic. The semi-structured interviews were tape recorded, with the permission of the participant and later transcribed by the researcher. The audio files were recorded on a disc as a back-up strategy and kept in a secured filing cabinet. The researcher

also collected field notes during data collection to supplement the recordings. All interviews were conducted in English. The semi-structured interviews lasted for 30 minutes each.

Data analysis: In this study, Nvivo 12 software was utilised to help organise the transcribed data. Findings were analysed using a thematic analysis approach. To allow themes to emerge from the data, inductive coding was also used. The researcher started the data analysis by carefully reading all the transcripts and developed a codebook in which initial codes were recorded. The initial codes comprised the ideas and topics that were commonly discussed by the participants. The researcher later amended the codebook through grouping similar codes into themes and identifying emergent relationships between different categories. In this paper, only ideas that appeared more frequently in almost all interview transcripts were considered for developing themes and included in the findings. The researcher regarded ideas that came up less frequently as too insubstantial to warrant being a finding, and thus excluded such ideas from the discussion. However, where an idea that appeared only once or twice across the whole dataset was included, it was presented not as a theme but as a 'deviant case' that stood in contrast to the developed themes. The researcher presented the results according to different themes pertaining to participants' perspectives and experiences. The researcher also did 'member checking' to validate the authenticity and check if the findings accurately reflect their perspectives. Preliminary data was shared with 50 percent of the study participants and incorporated their feedback in the final data analysis. This enhanced rigor and reduced bias of the researcher during the data analysis process.

Ethical Considerations: Ethical approval for this study was sought from the University of Cape Town Human Research Ethics Committee (HREC Ref: 366/2019), the School of Public Health and Family Medicine and Limpopo Department of Health. This study was done in partial fulfilment of the Masters in Public Health degree at the University of Cape Town (UCT) and due diligent was exercised to protect all study participants (before, during and after data collection). (See Appendix 3 & 4).

RESULTS

Description of participants

Persons who took part in this study were all professional nurses from the Nancefield clinic and the Musina hospital. A total of ten participants participated in the semi-structured interviews (70% women and 30% men). Their work experience ranged from 2-18 years. The biographical information of the participants is presented below;

Demographics	Number of participants
# of years of experience	
0-5	6
6-10	1
11-15	2
16-20	1
Gender	
Male	3
Female	7
Other	0
Race	
African	10
White	0
Mixed	0
Other	0
Professional status	
Enrolled nurse	0
Professional nurse	10

The researcher found out that the most experienced nurses were found at the hospital rather than in the clinic. There was no difference observed in the findings (based on their gender and number of years of experience) regarding their perceptions and practices on asylum-seekers and refugees. All participants were black Africans and registered professional nurses.

KEY THEMES

Distinguishing Asylum-Seekers and Refugees from Other Classes of Migrants

Participants incorrectly classified asylum-seekers and refugees as economic migrants. Despite being familiar with the terms, the majority of participants interviewed believed that asylum-seekers and

refugees were the same as economic migrants. To illustrate their difficulty in separating refugees and asylum-seekers from other classes of migrants, two participants said;

> *Asylum seekers they are economical refugees, we call them economical refugees because they ran away from their economies that are poor, so they came to the country.* (5+ years of experience).

> *Asylum seekers who are here looking for jobs or green pastures.* (8+ years of experience).

Participants generally believed that asylum-seekers are not different from economic migrants. Asylum-seekers and refugees are defined as those who move outside their country of origin because of well-founded fear of persecution based on religion, race, nationality, political opinion and membership of a social group (UNHCR) [14]. On the other hand, economic migrants maybe documented or undocumented but they leave their home country voluntarily to seek a better life; economic or otherwise. The failure to distinguish between the two by the participants presents a big challenge in rendering social welfare services to this vulnerable group. The inability on the side of the nurses to correctly classify asylum-seekers and refugees may enable or lead to violation of the rights of bona fide asylum-seekers and refugees. However, one participant was correct about the meaning of asylum-seeker and refugee.

> *I'm not too familiar, in my understanding its people either running away from war or fight/riots in their countries, that's my understanding of the two.* (3+ years of experience).

This participant once worked in the private sector where he often interacted with asylum-seekers and refugees. It indicated that those healthcare providers in the private sector either interact with various vulnerable groups or receive training from various stakeholders on key populations.

Contact with refugees and asylum-seekers

The majority of the participants inferred that they were in contact with asylum-seekers and refugees despite incorrectly classifying asylum-seekers and refugees as economic migrants. The participants had the view that majority of their patients or people accessing their services were economic migrants including asylum-seekers and refugees.

> *Yes, on a daily basis. They come from Zimbabwe, DRC, Ethiopia and I'm not sure about the other ones, they are Indians, from those other countries.* (2+ years of experience).

> *Yes, I came across many and majority of them are our neighbouring country Zimbabwe and from DRC, Malawi, and Burundi. Majority are from Zimbabwe.* (3+ years of experience).

Yes, most of our patients are those people. Sometimes they come and complain of headache, hot body, shivering, and malaria. Women come mostly to give birth. Those people do not stay here for a long time, most of them, they are here for either a year or two and after that they say we're going to Johannesburg. (12+ years of experience).

UNHCR[14] describes DRC, Zimbabwe, Ethiopia, Somalia, Sudan and Eretria as asylum-seeker and refugee producing countries. Most of these people flee persecution on at least one of five defined grounds as defined by the 1951 Convention (UNHCR) [14], thus qualify to be refugees and asylum-seekers. Based on the assertions above, nurses inferred that most of their patients were economic migrants including asylum-seekers and refugees.

Perceptions

Nurses could not distinguish between migrants' classes but migrants from Zimbabwe were mentioned repeatedly as regular patients at their facilities. For example, when exploring perceptions of the nurses about asylum-seekers and refugees accessing healthcare services, two participants said;

Nearly every day these people visit our facility and they outnumber our South Africans, so they have no reason to be denied…In Zimbabwe you need to pay first and so they are running away from Zimbabwe coming to this side. It's overburdening us now. We cannot transfer patients to that side because of the challenge. For us first it's treatment. (8+ years of experience).

Yes, they come here because they pay in Zimbabwe and when they come here it is free. In Zimbabwe and Mozambique they need money to pay. They should pay here also because sometimes there is shortage of medication – everyone must pay the same. Immunisation is often in short supply. People from that side come and give birth here and stay up to 3 – 6 months while the baby gets immunisation and when the baby is 6 months or a year old then they go back. When I ask them they say that side they want us to pay. They come here sometimes for free medication and they stay here next to us at the church and they get free food, they stay the whole day there not working, or others go to work there at the farmers. (5+ years of experience).

The above excerpts indicate that nurses were not happy with serving patients for free, especially migrants. These migrants are not perceived as deserving patients and end up being viewed as overburdening the health system. These asylum-seekers and refugees are viewed as medical tourists that just come to receive free treatment after which they go back. This perception could distort the rights refugees and asylum-seekers have in this country. Some participants even went further to question the authenticity of

migrants as patients. The interaction between nurses and migrants seemed to be characterised by mistrust and dishonesty. For example, when nurses were asked to describe their interaction with asylum-seekers and refugees, two participants said;

> *They don't appreciate, they always have a longer queue than South Africans. Always. They must treat us humanly. Assist us then we can assist you. Some of them sell the medication, especially those ones from Zimbabwe, especially December time, they come and take the medication to sell in Zimbabwe.* (14+ years of experience).

> *{Laughs} some are fine, normal patients being patient and friendly, some hey…they are normal patients who are not patient, who seems not to be taking responsibility for their own health. And some will come when they are doing shopping, especially when it's time for festives or Easter holidays, they do shopping, they will go to Musina hospital, get treatment, go to Musina clinic – the very same problem, the very same treatment, come to Nancefield clinic, the very same problem, the very same treatment, go for mobile, same treatment for the same problem. Four consultations, then they take the medication back home.* (2+ years of experience).

> *No, what I have noticed is that like now during festive season's right we usually have like… like medication compared to when it's not during the festive – because now during the festive season they tend to go back to their homes and then January they're coming back, there is a trend.* (2+ years of experience)

Nurses have a perception that most migrants including asylum-seekers and refugees do not use their medication properly. Most nurses believed that most migrants who pose as patients may not be genuine patients.

Practices

The majority of nurses indicated that they don't check if someone was documented or undocumented when rendering their services. They had the view that it is not in the best interest of their patients. Not checking the identity documents of their patients was illustrated when three nurses said;

> *We don't even ask for their passport or asylum when we treat you. As long as the patient knows their name and their date of birth that is what is most important.* (8+ years of experience).

> *I don't check their id book because I am not the one who registers them. To me if the patient comes with a file, I admit the patient. I don't ask for the id book or whatsoever.* (5+ years of experience).

*No, we treat many with no documentation, passports or id and when they explain we understand they did not come the right way. When somebody is sick they're sick whether they have papers or not. Our main concern is to help and not papers because we are not the department of home affairs, but department of health. (*3+ years of experience).

Nurses said that they apply the law in their practices as expected. The law is clear when it states that refugees and asylum seekers with or without a permit should not be denied access to basic health care and anti-retroviral treatment and that the South African Identity book should not be made a prerequisite in accessing health care services (Moyo) [4]. However, misrepresentation of identity was an issue to most nurses.

I don't know if I have to say this, but in this facility, it's either you having an id or not. They just let you in, so it's not like we denied service directly we had issues when it comes to id books. There are people who come with id books and when we identify them, it's not theirs, so in that case we have to send them to our seniors so that they can come to a conclusion on how are we are going to help this patient. But then we have to weigh the severity, if ever the patient is fit like is supposed to get help…like let's say maybe it's an emergency we can't send the person home, but if it's a minor case, then it means the patient can go back and bring back the owner of the id and then we solve that issue. (2+ years of experience).

Another participant also said;

He just tells you that my name is ABC, the very same person will come in less than a month and say my name is DEF, the following month you will find that person on the first or second visit some tests or investigations were done. Now, you are supposed to attend to her. She will tell you that my name is XYZ, then you'd want to run certain tests then she says no, they did those tests. When you check the date it's ABC, then you say no we did on ABC and they say yes that's me again. I'm ABC and I'm XYZ. So right there, surely I cannot attend to you. (2+ years of experience).

From the above excerpts, it is clear that nurses took misrepresentation of identity seriously. The consequence of being caught lying about your identity were high and sometimes treatment was denied. Nurses said those caught lying were requested to bring the owner of the ID to confirm or get referred to seniors at the facility. Need to clarify that this is because the wrong identity makes it hard to keep records and treat them properly (and not a punishment for being undocumented).

Decision Making

Most nurses referred to their nursing policies and guidelines as the source of their decision making process. Nurses did not acknowledge that their values and beliefs also play a role when making decisions. Largely they said decisions are derived from guidelines and policies of nursing in South Africa. To illustrate sources of their decision making, three participants said;

> *I haven't returned anyone, unless it's like after hours because we're having an internal policy that after hours we're only treating emergency. Whether you are a South African or foreigner or refugee or asylum seeker, as long as you came after hours and it's not an emergency, you won't be treated. But if it's an emergency we treat everyone.* (5+ years of experience).
>
> *We follow the nursing process. I think they are being treated like anyone else. We don't have to say this one is a refugee, is an asylum seeker or is a citizen. We are being guided by our clinical guides. We treat everyone according to the guide.* (5+ years of experience).
>
> *The very same thing that informs us when making decisions to treat South Africans. As nurses, we have guidelines and we have protocols those are the things we use, regardless of race…* (2+ years of experience).

Two participants said;

> *I pledged that I will treat any patient, regardless of his culture, his colour, whatsoever - everyone is a patient in front of me. The patient comes with a file already written by the doctor for me to do this and this to the patient, that is what I do. I don't take decisions. The doctor writes everything and I have to do everything the doctor has written, as per doctors' orders. I'm not the one who is diagnosing or prescribing treatment, only the doctor prescribes treatment and diagnose.* (5+ years of experience).
>
> *Mostly when patients come in here, they have been referred by the doctors, so if a doctor refers a patient here the patient should get help and I help them.* (18+ years of experience).

The above extracts show that participants get directions from both doctors and working documents such as policies, guidelines and protocols. Nurses believe in work documents and hierarchy of power. These two factors provide guidance to nurses when interacting with asylum-seekers and refugees accessing their services. Some participants indicated that they also make their decision based on the condition or severity of the illness of the patient.

Types of Health Services Rendered to Refugees and Asylum-Seekers

Nurses argued that asylum-seekers and refugees receive all the services that are given at their facilities. However, nurses said that they are also prone to certain illness hardly experienced in South Africa like malaria. For example, when asked what types of health services were being rendered to migrants, three participants responded;

> *Sometimes they come here tired from the que (exhausted) we treat them when they're sick, different illnesses.* (14+ years of experience*).*

> *All services, primary and secondary health care, even operations, they even get ARV treatment here.* (8+ years of experience).

> *Sometimes they come and complain of headache, hot body, shivering, and malaria. Women come mostly to give birth. (*13+ years of experience).

The other participant was very specific on the types of illness that asylum-seekers and refugees experience. The participant said;

> *Majority from Burundi suffer from Malaria and I think 5 or plus cases were treated malaria but severe cases were transferred to hospital. (*3+ years of experience).

Clearly, nurses are giving all services to migrants and even show that they have knowledge about some illnesses that this population group is prone too. Having this information is good to nurses for screening and monitoring purposes.

Challenges Experienced by Nurses When Interacting with Migrants

1. Medical history

Some participants indicated that having a written medical history is paramount when dealing with emergency cases and it saves time. For example, when asked about her interaction with asylum-seekers and refugees, one participant responded;

> *Even if it can be medical records so that we do not start from scratch, because some other things delay treatment when we start from scratch. You can't just come in here and say I'm taking treatment for my eyes. The treatment is 123 then you think we just give that, no, we have to run some test and be 100% sure that this is the person who is having this problem and all that, because some collect treatment for their magogo's at home.* (2+ years of experience).

The above quotation shows that nurses prefer to have a written and accessible medical history of their patients. Having medical history of their patients lessens their workload as indicated. Also, lack of trust between nurses and patients prompt nurses to suspect that most migrants including asylum-seekers and refugees fetch treatment for someone who is undocumented or at home.

2. Misrepresentation of identity

Most participants believed the names given by the migrants when they register at their facilities may turn out to be false. This behaviour negatively affected the perception of nurses on refugees and asylum-seekers seeking treatment. Nurses do not understand the reasons behind misrepresentation of identities but reiterates that it negatively impacts on monitoring the health condition of their patients. For example, when participants were asked about misrepresentation of identity by migrants, they had this to say;

> *With regards to patients, most of the foreigners lie. They are dishonest. Today you are Taurai when your relative comes you are David and this complicates our documenting system. We need continuation so that we can monitor your condition.* (8+ years of experience).
>
> *The challenge we have is they always change their names at every visit, they are dishonest. They must use their real names.* (13+ years of experience*).*
>
> *I think they must regulate that every person who come here must have an identity document, because like today we had someone who was having someone's id registering her as that person. We are at work and are here to render a service but we are humans. In that case I mean, that patient I'm going to render her services but I don't know…I don't know how to put it, but I am emphasizing that every patient must have their id documents, asylum or whatever can be used to identify them because that one is a challenge, as long as they have their documents then all is well.* (2+ years of experience)
>
> *Normally we treat, depending on what they're wanting. It becomes a challenge when the person is on chronic medication and is giving wrong details, that's when you find the person comes in today and tomorrow they come in with another name and you're forced to open a new file. We will be having duplicated files. Others are so clever, they know that this week I will get a certain shift, next week I will be having a certain shift, they might come this week and say my name is whoever with the previous file and then come the following week with a duplicate of the file and they mention the other name then... we tend to get surprised when the person is giving you… at times they mix their books, you find that the written date is mentioning something else and the*

thing is something else. That is when we tend to notice and ask – ok you were given medication on this date what happened (2+ years of experience).

From this, participants develop stereotypes about migrants who are seeking healthcare services because of a few who misrepresented their identities. Clearly it became difficult for most nurses to individualise patients thereby leading to overgeneralising based on their experiences.

3. Language

Findings reveal that most of the participants had challenges communicating with migrants seeking healthcare services at their facilities. Most of the asylum-seekers and refugees came from non-English speaking countries. Communication is crucial when nurses give treatment to migrants.

*I think it's difficult because of language barrier, most of them are from DRC, Burundi and they speak French or Swahili so if you're not familiar with the languages you will be in trouble. At least I have a little understanding of the languages now sometimes I interpret for our staff here. I learnt this while I was working in Uganda. Language barrier is a problem as you'll be treating someone you can't communicate with clearly (in sign language), it's not good with health stuff we have to go deeper. (*3+ years of experience).

If there is no communication it becomes problematic, maybe I should learn their language it may be better, but it is also not easy at my age to learn a new language. (18+ years of experience).

Not very long I had a lady from DRC and she couldn't speak English or any other South African language. I was very difficult, sometimes she would understand some things and at times nothing, then I ended up asking her if there is someone she knew around who could assist her so that we can communicate. She ended up giving me a name and a number and I called the person, luckily the person admitted to help and they came and assisted. (18+ years of experience).

Nurses did acknowledge that they experience language problems when rendering their services to migrants who are not proficient in any local language. Some of the nurses indicated that they seek interpreters within these migrants' groups.

4. Facility budget

Some nurses were not happy about the budget that the provincial government allocated to their facility. For example, when asked about things needed to be done to improve interactions with asylum-seekers and refugees, one participant said;

> *In that case, everyone has the right to get services, so I'm not against them getting treatment from our facility, for as long as when they do their budget, they must have…bear in mind that we're at the border and when we're at the border, they must not take it like this budget only has to render services to South Africans.* (2+ years of experience).

Clearly, participants felt that resources that were being allocated could not accommodate both locals and migrants sufficiently. Lack of resources can lead to rationing that could affect access of health service and migrants largely impacted.

5. Number of refugees and asylum-seekers accessing healthcare services

All of the participants believed that migrants accessing their services are more in number than the local citizens. This perception that migrants who are accessing their services are more in number than the locals made nurses feel like migrants were straining their services. When participants were asked to give estimates of asylum-seekers and refugees accessing their services based on their daily interactions with asylum-seekers and refugees. These three participants said;

> *As I am speaking now this ward caters for 24 patients you will find that 20 are from outside and only 4 are South Africans.* (5+ years of experience*).*
>
> *Ah! Most of the patients are those people, out of 10 patients, maybe there'd only be 1 South African.* (13 years of experience*)*
>
> *Weekly you may find that if you admit 20, 11 – 12 patients would be from outside (foreign nationals).* (8+ years of experience).

The participants are clearly in contact with many non-south Africans but fail to distinguish between them. This broad categorisation makes everyone from outside South Africa to be treated the same. Refugees and asylum-seekers should be treated as nationals of South African based on the laws of the country. This failure to distinguish between classes of migrants maybe creating a perception that asylum-seekers and refugees are more in number than the nationals.

Suggestions from Nurses

1. Documentation

The majority of the participants had the view that migrants accessing their services must document their legal presence. The participants were asked what they would want to do to improve their interactions with refugees and asylum-seekers. Most of them reiterated the importance of documentation (legal presence) as illustrated by the following nurses' remarks;

> *They must have documentation for identification, it would make the work easier. It may be better to employ those people or interpreter(s).* (13 years of experience).

> *The thing of the passport and then asylum and refugee - it's tempering with our safety because people are just entering the gate without being identified. Just imagine if somebody comes in without an id or anything, comes and attack us inside then the person leaves, who we are going to say it is. We're just going to look at the register? We say it was Simon Ndlovu or whoever and check the person's name isn't theirs. We are proposing that they can come in, if they are not having asylums they can use their identification from back home because mostly if you ask for asylum if they don't have, they produce, especially Zambians and DRC ones they produce their id's from home, so we just thought it would be best to say if the person does not have their asylum with them they can use their id's from home so that they can be identified.* (5+ years of experience).

> *I think they must regulate that every person who come here must have an identity document, because like today we had someone who was having someone's id registering her as that person. We are at work and are here to render a service but we are humans. In that case I mean, that patient I'm going to render her services but I don't know…I don't know how to put it, but I am emphasizing that every patient must have their id documents, asylum or whatever can be used to identify them because that one is a challenge, as long as they have their documents then all is well. (*2+ years of experience).

From the above excerpts, participants emphasized the importance of documentation as it serves both migrants and nurses. The reasons for documentation ranges from nurses' safety to migrants' easy access to social services. Participants indicated that they feel comfortable working with people who have identity documents.

2. Strengthening the Health System

The majority of the participants had the view that nurses need to be empowered so that they can be able to work with this specific population group competently. Consequently, empowering these participants will result in enhancing the health system. For example, when participants were asked to suggest ways

related to language can enhance their interactions with refugees and asylum-seekers, two participants said;

> *This thing I think I said it at one point when we had a dialogue with our district office and the province was here, so I think similar questions that you are asking were asked and so I suggested we should be trained on how to handle these brothers of ours. We can be taught their language and even they can teach us Shona, Ndebele (I know because we can speak Zulu here), Swahili, French – those are the main languages that we are catering this side, it will be better, because if I speak your language then I'm speaking into your heart and if I'm speaking a foreign language then I' speaking into your head – so says Nelson Mandela. I think if we can have programmes on immigrants and asylum seekers, especially health programmes - we do have but they are lacking something there because we come across some situations where we don't even know we should cater until where. So, I think programmes are needed were they are stipulating how we can cater for them. Primary health care is fine, I know it's there we cater them, but secondary they do have some challenges and tertiary is worse. So, if we can have programmes that are clearly table that this person is from here to here so that I'm confident if I refer this person to tertiary they will be helped.* (3+ years of experience).

> *I don't know if other people would be interested but I think we must be…as people working at the border, we must have extra lessons on… firstly they must check that the majority of people from other countries, where are they coming from? If from DRC, it means we must be at least familiar with their first language, like French.* (2+ years of experience).

Other participants focused on strengthening the health system from a macro level. Two other participants had this to say;

> *We need to strengthen our social development and health. (5+ years of experience).*

> *We need the health systems between South Africa and Zimbabwe to help each other. In South Africa, we treat patients and then they pay later. In Zimbabwe, you need to pay first and so they are running away from Zimbabwe coming to this side. It's overburdening us now.* (8+ years of experience).

Nurses wanted more to be done to strengthen their capabilities so that they can work with all patients including migrants in South Africa and also improve access to healthcare services.

3. Involvement of International Organisations

Some participants also had the view that external players need to take part in ensuring universal health coverage. They had the view that their health system still needs assistance from the external players to improve access and attain universal health coverage. To illustrate that, participants were keen to see international organisations involved, the following remark was made by the participant;

> *I think that UN can do something to other countries so that health services can be improved, as some of them just come here for just treatment. Here in the ward we have more than 10 who came only for treatment, not for asylum seekers or seek refugee only for treatment and most of them are from Zimbabwe.* (5 years of experience).

Participants were of the view that the number of migrants receiving treatment at their facilities were too much. Clearly, nurses also want to see health systems from other regional countries strengthened. The perception that nurses had towards migrants was not healthy and could hinder accessibility of healthcare services.

4. Cross-Border Health Forums and Political Will

Some participants indicated the need to revive cross-border health forums that used to be done between Southern African Development Community (SADC). Also, the political will from governments to ensure no one is left behind towards universal health coverage was an issue to the nurses. One participant said;

> *… But I don't know because sometimes our government used to have meetings there at Beitbridge… We need the health systems between South Africa and Zimbabwe to help each other. Their economy, there is no money there, it will take years for it to pick up. We are still going to have them here till we go ancient, that thing needs politicians*. (5+ years of experience).

Clearly, participants were concerned about the situation and need something to be done. Nurses acknowledged that economy plays a critical role in stabilising health system. Nurses also expected action to be taken especially by those in position of power.

5. Interpretation Services

The majority of the participants reflected that their facilities do not have translators to cater for migrants who cannot converse in any local languages. Asylum-seekers and refugees who cannot converse in any local languages were expected to have access to a translator. One participant said;

*If they come here we only use English, most come with their friends for interpretation. When they don't have, we call someone from the church there are lots of them who can assist. (*5+ years of experience).

Nurses indicated that language is important when giving their services. They also inferred that those who cannot access interpreters could be at risk of not receiving what they exactly needed.

DISCUSSION

The findings from this study provide insights into nurses' perceptions and practices with regards to asylum-seekers and refugees accessing healthcare services. South Africa has an estimated 4 million migrants (IOM) [15], among those 286 000 are refugees and asylum-seekers (UNHCR South Africa) [16]. Most nurses were incorrectly classifying asylum-seekers and refugees as economic migrants. The inability of nurses to correctly classify asylum-seekers and refugees may enable or lead to violation of the rights of bona fide asylum-seekers and refugees. Refugees and asylum-seekers ought to be treated as South African citizens in terms of the right to health, especially in secondary and tertiary healthcare facilities (Constitution of South Africa, National Health Act of 2003, Refugee Act of 1998)[5, 6, 17]. Those nurses who are able to correctly distinguish asylum-seekers and refugees from other classes of migrants had a background in private sector. This showed that those nurses working in the private sector might have more exposure to vulnerable populations.

Having a clear understanding of migrant classes is key for nurses and would assist them in understanding the populations they serve. This could help in facilitating their services effectively and efficiently. Most nurses had the view that most of their patients were economic migrants. This perception from nurses could cause them not to be objective due to their perceived reality that migrants accessing healthcare are more in number than South African citizens. Gilson & Lipsky[18] believe that in this work environment, frontline workers cannot deal with patients on an individual basis therefore they develop work practices that institutes mass processing of their patients. The patients' dilemma is particularly critical if he or she is from a different racial background, religion, or socio-economic class to the nurses. At best, nurses develop modes of mass processing that allow them to deal with patients fairly and at worse they give in to stereotyping, favoritism and rationalising, all of which are not in the best interest of the patients (Gilson & Lipsky)[18]. As a result, the level of access to public services is influenced.

Nurses reported not being happy with serving patients for free, especially migrants because they perceived them as not 'deserving' patients therefore resulting in the overburdening of the health system. Due to this view, this already prejudiced group could experience medical xenophobia. Medical xenophobia

affects access to healthcare services and has a negative impact on universal health coverage commitment largely (Moyo) [4].

Nurses had the view that that their health system still needs assistance from the external players to improve access and attain universal health coverage. The interaction between nurses and migrants seemed to be characterised by mistrust and dishonesty. Trust and honesty may require some time and consistency to develop, of which it is difficult to achieve within an already overburdened system. Trust usually gets eroded by past bad experiences even before refugees and asylum-seekers enter the country as well as afterwards (Mckeary & Newbold) [19]. Also, trust gets compromised in situations of power or when asylum-seekers and refugees are omitted from decisions (Hynes) [20], particularly if the person is fearful that too much information could result in denial of refugee claims. Issues regarding trust need to be taken seriously by nurses when working with asylum-seekers and refugees. As noted by Hynes[20], "making space for trust should be a priority, with trust between provider and refugee serving to reinforce health".

Nurses indicated that having a written medical history is vital when dealing with emergency cases and it saves time. However, the majority of asylum-seeker and refugees arrive without their medical history hence delay of treatment. Nurses revealed that language was a barrier to accessing healthcare services by patients from non-English speaking countries. Pottie, et al.[21] concur with findings of the study on the issue of language and further associated it with poor health outcomes. Also, it strains an already weak relationship, thus affects accessibility of healthcare services especially by vulnerable populations. Interpreters need to be available and the budget of public facilities needs to include interpretation costs, hence a step closer to attaining universal health coverage by 2030. Nurses requested more training on cultures of refugees and asylum-seekers so that they can be more culturally sensitive when rendering their services to them. This training could assist them to reflect on their own and others cultural beliefs, attitudes, behaviours and communication strategies and modify work routines that enable quality and impartial care (Guilfoyle et al.)[22]. Migrants accessing their services must document their legal presence. Nurses acknowledged that economy plays a critical role in stabilising health system. Nurses also expected action to be taken especially by those in position of power.

STRENGHTS & LIMITATIONS

These results are based on a qualitative study conducted at the Nancefield clinic and the Musina Hospital, so they cannot be generalised. The results do not represent the opinions and experiences of all nurses

working at the Nancefield clinic and the Musina hospital because the sample size for this study was relatively small. Also, the results also do not represent the perspectives of all nurses, particularly enrolled nurses. However, despite these limitations, this study provided an opportunity to explore perceptions and practices of nurses with regard to asylum-seekers and refugees accessing healthcare services, information that is currently missing in improving migrants' health and attainment of universal health coverage. The study assisted in exploring new information from the nurses' point of view, shedding light on the perceptions and practices of nurses and generally, public health facilities. Although not generalisable, the results from this study are transferable. Generalisability encompasses broad claims; transferability invites readers to make connections between aspects of the research and their own experiences. [23]A detailed description of the study context and methods helps readers to make informed decisions and determine which aspects of this research can be transferred to their own situations

RECOMMENDATIONS

As a result of this research, the following recommendations have been made;

1) Stakeholders that are working with refugees and asylum-seekers should conduct capacity building activities with nurses to raise awareness or government request trainings.
2) Public health facilities should make interpretation services a priority if they wish to attain universal health coverage
3) Department of Home Affairs should have a system that assists in identifying everyone within the borders of South Africa.
4) Government departments should participate in inter-agency forums that deal with migrant issues.
5) The study, of course, raises further questions and directs areas for further research. The study should be replicated with a larger sample as the sample size was too small to allow generalisation. Also, the researcher conducted this study with participants of different culture and language; this could have influenced the quality of information shared because the participants could view the researcher as an outsider. The researcher recommends someone who shares the same culture, language, and background to conduct the same study in order to explore this study deeper.

CONCLUSION

This is the first study to be conducted in Musina to explore perceptions and practices of nurses on asylum-seekers and refugees accessing health care. Therefore, it contributes to the existing lack of evidence in this area. The study provided some insight on the perceptions and practices of healthcare providers. Due to the small sample size of the size, it cannot be concluded that there is no systematic discrimination of

asylum-seekers and refugees in South Africa. Nurses lack knowledge on different classes of migrants. Nurses also have the view that majority of their patients on a daily basis are migrants including asylum-seekers and refugees. They feel that the health system is being overstretched without enough resources to compensate on the services rendered. Nurses also experience challenges when working with migrants which may include, language barriers, trust issues and lack of medical records, therefore they are requesting to be trained in order to have skills to properly deal with migrants including asylum-seekers and refugees.

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Author contributions: Mr. T. Ndemere framed the research question, research design, data collection and analysis and drafted the initial manuscript. Associate Prof. C. Colvin oversaw the work throughout the whole process. Co-author also reviewed and contributed to the final manuscript

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Disclaimer: The views or opinions conveyed in this article are the authors' own and not an official position of the University of Cape Town.

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PART D: APPENDICES

APPENDIX 1: Consent Form for Individual interview

The following consent form is for nurses working at the Nancified clinic and the Musina hospital, who will be invited to participate in the following study.

Principle investigator: Taurai Ndemere

Co-investigator: Associate Professor Christopher Colvin

Name of project: Perceptions and Practices of nurses with regards to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa.

Study site (s): The Nancefield clinic and The Musina hospital

Section 1: **Information sheet**

Introduction

To achieve the goal of universal health coverage, no one should be left behind. To achieve this goal, refugees and asylum seekers should be prioritised due to their heightened risks. This would improve health outcomes and assist in attaining sustainable development goals (SDGs) of 2030. In the South African context, numerous studies have been conducted on access to health care services from asylum-seekers and refugees' perspectives (World Health Organisation and World Bank, 2017). Because it is a complicated problem, however, both the service providers' point of view and that of the patient need to be explored and understood deeply for effective action to be taken. However, there is a lack of studies from the service providers' (nurses) point of view on asylum-seekers and refugees accessing healthcare services, specifically in Musina, Limpopo, South Africa.

Purpose of the research

The study seeks to explore perceptions and practices of nurses with regards to asylum-seekers/refugees accessing health care services in Musina, Limpopo, South Africa. We would like to find out different opinions of people about refugees and asylum seekers accessing health services and how they are supposed to be treated. We also want to explore what guides and drive their perceptions.

Study Procedures

If you choose to participate, the researcher will tell you about your role in the study. You are invited to participate in an individual interview, which will be conducted by the researcher at …… (Place). The interview will be conducted in English. Each interview will take approximately 30 minutes. The interview will open with a short brief explanation about the study. During the interview, you will be asked to share your opinions and experiences with regards to asylum-seekers /refugees accessing health care services. However, you are not obliged to share any information that you are uncomfortable divulging. At the end of the interview, the researcher will give you an opportunity to ask any question that you might have. The interview will be recorded, with your consent. If you don't want to be recorded, we won't do so. You can be assured that you will remain anonymous and the tape kept safe and secure. All information will be kept private. Only the researcher and his supervisor will have access to the interview recordings. After the recordings have been transcribed, the tapes will be completely destroyed.

Confidentiality and anonymity

The information collected during the interview will be kept confidential and stored on password-protected computers. However, my supervisor and the research ethics committee may inspect the research records if required. To safeguard your identity, pseudonyms shall be used.

Voluntary participation/Right to refuse or withdraw

Participation in this study is voluntary. You have the right to refuse or withdraw from the study at any given stage if you wish. You can freely do so without any consequences. Your withdrawal or refusal to participate will not affect your relationship with the researcher. You can also ask the researcher to change or remove certain parts of the information gathered if you feel that he/she has not understood you correctly.

Benefits

The study will be used to motivate for capacity building activities of nurses working directly with asylum seekers and refugees, which will directly enhance accessibility of services by this vulnerable group.

Risks

There is a minimum risk to participants associated with the study. Sharing your perceptions can trigger emotions that may cause discomfort. If there is any discomfort caused by the study, you will be referred for counselling at Future Families Organisation. Future Families renders free counselling to anyone in Musina.

Who to contact

This study has been reviewed and approved by the University of Cape Town Human Research Ethics Committee, who are responsible for overseeing the safety, rights, and welfare of human participants in research. If you have any concerns or questions at any given point during the study, you may contact either the UCT Human Research Ethics Committee on **021 406626** or Associate Prof. Chris Colvin on **021 605 1487**. You are free to ask any questions about this study, if you wish to.

Part 2: Informed consent

I…… have been invited to participate in research study; "Perceptions and practices of nurses with regards to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa". I have read the information sheet. I have been given the chance to ask questions about the study and my questions have been answered to my satisfaction. I voluntarily give consent to participate in this study.

Print name of participant: …….

Signature: ……..

Date: …….

APPENDIX 2: Interview Guide for Nurses

Perceptions and practices of nurses with regards to Asylum-seekers & refugees accessing health services in Musina, South Africa

Semi-structured interview with nurses (after informed consent has been taken)

Repeat Introduction

1. My name is Taurai Ndemere and I am a Master of Public Health Student from the University of Cape Town. I am also a social worker by profession.
2. I would like to ask you some questions about your opinions and experience on asylum-seekers & refugees accessing health services at your facility. The purpose of the study is to explore perceptions and practices of nurses with regards to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa. Any questions before we get started?

Background

3. Please, what is your name?
4. How long have you worked in this facility?
5. Have you ever come in contact with patients that are not South Africans? From which country do these patients mostly come from?
6. People from other countries might be tourists, or immigrants or they might be asylum-seekers and refugees. Are you familiar with these last two terms? How would you define asylum-seekers and refugees? What do those terms mean to you?
7. Have you ever treated asylum-seekers/refugees in this facility? Which kinds of health services do you provide to them?
8. About how many asylum-seeker/refugees seek treatment in this facility on a daily basis?
9. From your interactions with them, what do you think about asylum-seekers and refugees accessing health services at your facility? What are your interactions with them like?
10. Do you think asylum-seekers/refugees should have the same access to health care services in this country as citizens have? There is no right or wrong answer. I am really interested in what you think about this question.
11. Can you tell me a bit more about why you feel this way about the issue? Have you always felt this way?

12. According to certain studies and media reports, asylum-seekers and refugees are sometimes denied primary health care services. Does this happen in this facility? If so, why? If not, why not?
13. Have you ever been in a position where you had to deny treatment to a patient because they did not have an ID book/passport? If yes, how often do you find yourself in this position?
14. Does this also happen with undocumented citizens? If yes, what do you usually do in this situation?
15. How do you make decisions when it comes to treating asylum-seekers and refugees? What do you consider in your decision-making process?
16. How do you differentiate between citizens and foreigners if both are not documented?
17. What is your experience with asylum-seekers/refugees that do not speak any of the local languages? How do you handle these interactions?
18. Have you ever had any asylum-seekers/ refugees that you could not help? How did you handle those situations?
19. What do you think can be done to improve your interactions with this group of people?

APPENDIX 3: HREC Ethics Approval Letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumaya.laher@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

23 September 2019

HREC REF: 366/2019

A/Prof C Colvin
Public Health & Family Medicine
Social and Behavioural Sciences
Falmouth Building, Room 3.46

Dear A/Prof Colvin

PROJECT TITLE: PERCEPTIONS AND PRACTICES OF NURSES WITH RESPECT TO ASYLUM-SEEKERS AND REFUGEES ACCESSING HEALTH CARE SERVICES IN MUSINA, LIMPOPO, SOUTH AFRICA (MASTERS CANDIDATE - MR T NDEMERE)

Thank you for your response, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 September 2020.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: Mr T Ndemere will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

NHREC-registration number: REC-210208-007

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use: Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines. The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

APPENDIX 4: Limpopo Department of Health Ethical Approval Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref : LP- 201909 - 011
Enquires : Ms PF Mahlokwane
Tel : 015-293 6028
Email : Kurhula.Hlomane@dhed.limpopo.gov.za

T Ndemere

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

Perceptions and Practices of Nurses with respect to Asylum Seekers and Refugees accessing Health Care Services in Musina, Limpopo, South Africa.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
   b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   e. The approval is only valid for a 1-year period.
   f. If the proposal has been amended, a new approval should be sought from the Department of Health.
   g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

Signature Removed

Head of Department DATE

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

APPENDIX 5: Musina Approval Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

MESSINA HOSPITAL

REF: S5/2/6/1/1
Enq: Radzilani A.C
DATE: 03 December 2019

DEPARTMENT OF HEALTH
MESSINA HOSPITAL - H.R.M. OFFICE
03 DEC 2019
PRIVATE BAG X[illegible] MUSINA 0900
LIMPOPO PROVINCE

FROM: HUMAN RESOURCE DEVELOPMENT

TO: T Ndemere
Faculty of Health Science
University of Cape Town

RE: PERMISSION TO CONDUCT RESEARCH AT MESSINA HOSPITAL UNDER THE STUDY TOPIC: PERCEPTION AND PRACTICE OF NURSES WITH RESPECT TO ASYLUM SEEKERS AND REFUGEES ACCESSING HEALTH CARE SERVICES IN MUSINA, LIMPOPO PROVINCE, SOUTH AFRICA

1. The above matter has reference.
2. This office wishes to inform you that your application has been approved as per conditions stipulated on your letter of permission granted by Head of Department. You are requested to liaise with HRD office regarding your commencement date.
3. Your co-operation will be highly appreciated.

Signature Removed

CHIEF EXECUTIVE OFFICER

2019.12.04
DATE

EXCELLENCE IS OUR PASSION

CNR CALDERWOOD AND WHITHYE STREET, PRIVATE BAG X 4006, MESSINA, 0900 TEL: (015) 534 0446, FAX: (015) 534 0809

APPENDIX 6: Manuscript Cover Letter

Manuscript #DD no

AOSIS

MANUSCRIPT COVER LETTER

This scholarly journal MANUSCRIPT COVER LETTER (title page) must be completed and submitted to AOSIS by the corresponding author as a supplementary document, at the manuscript submission point on to the journal website.

MY MANUSCRIPT			
Manuscript title: Perceptions and Practices of nurses with respect to asylum-seekers and refugees accessing health care services in Musina, Limpopo, South Africa			
No of words (cross-check your word count with author guidelines): 6758	No of tables: 1	No of figures: 0	No of pages: 22

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Author 1:	Author 11:
Full Name: Tsanai	Full Name:
Surname: Ndemera	Surname:
Email: tsanaindemera@yahoo.com	Email:
Phone: +27717268208	Phone:
Cell: +27717268208	Cell:
ORCID: https://orcid.org/0000-0002-5966-5416	ORCID:
Affiliation of Author 1:	*Affiliation of Author 11:*
Department: School of Public Health and Family Medicine	Department:
Faculty: Health Sciences	Faculty:

Physical Address: 70 Oxford Street, Durbanville, 7550.
Postal Address: Postnet Suite 110, Private Bag X19, Durbanville, 7551.
Phone: 086 1800660 or +2021 975 2602 | Fax: +27 21 975 4430 | Email: info@aosis.co.za | URL: www.aosis.co.za

Institution and/or University: University of Cape Town	Institution and/or University:
City: Cape Town	City:
Country: South Africa	Country:
Author 2	**Author 12**
Full Name: Christopher	Full Name:
Surname: Colvin	Surname:
Email: coldvine@gmail.com	Email:
Phone: 0846847202	Phone:
Cell: 0846847202	Cell:
ORCID: https://orcid.org/0000-0002-5966-541	ORCID:
Affiliation of Author 2	*Affiliation of Author 12*
Department: School of Public Health and Family Medicine	Department:
Faculty: Health Sciences	Faculty:
Institution and/or University: University of Cape Town	Institution and/or University:
City: Cape Town	City:
Country: South Africa	Country:
Author 3	**Author 13**
Full Name:	Full Name:
Surname:	Surname:
Email:	Email:
Phone:	Phone:
Cell:	Cell:
ORCID:	ORCID:
Affiliation of Author 3	*Affiliation of Author 13*
Department:	Department:
Faculty:	Faculty:
Institution and/or University:	Institution and/or University:
City:	City:
Country:	Country:
Author 4	**Author 14**
Full Name:	Full Name:
Surname:	Surname:
Email:	Email:
Phone:	Phone:
Cell:	Cell:
ORCID:	ORCID:
Affiliation of Author 4	*Affiliation of Author 14*
Department:	Department:

APPENDIX 7: Journal Submission Guidelines

Cover Letter

The format of the compulsory cover letter forms part of your submission. Kindly download and complete, in English, the provided **cover letter**.

Anyone that has made a significant contribution to the research and the paper must be listed as an author in your cover letter. Contributions that fall short of meeting the criteria as stipulated in our policy should rather be mentioned in the 'Acknowledgements' section of the manuscript. Read our **authorship** guidelines and **author contribution** statement policies.

Original Research Article full structure

Title: The article's full title should contain a maximum of 95 characters (including spaces).

Abstract: The abstract, written in English, should be no longer than 250 words and must be written in the past tense. The abstract should give a succinct account of the objectives, methods, results and significance of the matter. The structured abstract for an Original Research article should consist of six paragraphs labelled Background, Aim, Setting, Methods, Results and Conclusion.

- Background: Summarise the social value (importance, relevance) and scientific value (knowledge gap) that your study addresses.
- Aim: State the overall aim of the study.
- Setting: State the setting for the study.
- Methods: Clearly express the basic design of the study, and name or briefly describe the methods used without going into excessive detail.
- Results: State the main findings.
- Conclusion: State your conclusion and any key implications or recommendations.
  Do not cite references and do not use abbreviations excessively in the abstract.

Introduction: The introduction must contain your argument for the social and scientific value of the study, as well as the aim and objectives:

- Social value: The first part of the introduction should make a clear and logical argument for the importance or relevance of the study. Your argument should be supported by use of evidence from the literature.
- Scientific value: The second part of the introduction should make a clear and logical argument for the originality of the study. This should include a summary of what is already known about the research question or specific topic, and should clarify the knowledge gap that this study will address. Your argument should be supported by use of evidence from the literature.
- Conceptual framework: In some research articles it will also be important to describe the underlying theoretical basis for the research and how these theories are linked together in a conceptual framework. The theoretical evidence used to construct the conceptual framework should be referenced from the literature.
- Aim and objectives: The introduction should conclude with a clear summary of the aim and objectives of this study.

Research methods and design: This must address the following:

- Study design: An outline of the type of study design.
- Setting: A description of the setting for the study; for example, the type of community from which the participants came or the nature of the health system and services in which the study is conducted.
- Study population and sampling strategy: Describe the study population and any inclusion or exclusion criteria. Describe the intended sample size and your sample size calculation or justification. Describe the sampling strategy used. Describe in practical terms how this was implemented.
- Intervention (if appropriate): If there were intervention and comparison groups, describe the intervention in detail and what happened to the comparison groups.
- Data collection: Define the data collection tools that were used and their validity. Describe in practical terms how data were collected and any key issues involved, e.g. language barriers.
- Data analysis: Describe how data were captured, checked and cleaned. Describe the analysis process, for example, the statistical tests used or steps followed in qualitative data analysis.
- Ethical considerations: Approval must have been obtained for all studies from the author's institution or other relevant ethics committee and the institution's name and permit numbers should be stated here.

Results: Present the results of your study in a logical sequence that addresses the aim and objectives of your study. Use tables and figures as required to present your findings. Use quotations as required to establish your interpretation of qualitative data. All units should conform to the **SI convention** and be abbreviated accordingly. Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

Discussion: The discussion section should address the following four elements:

- Key findings: Summarise the key findings without reiterating details of the results.
- Discussion of key findings: Explain how the key findings relate to previous research or to existing knowledge, practice or policy.
- Strengths and limitations: Describe the strengths and limitations of your methods and what the reader should take into account when interpreting your results.
- Implications or recommendations: State the implications of your study or recommendations for future research (questions that remain unanswered), policy or practice. Make sure that the recommendations flow directly from your findings.

Conclusion: Provide a brief conclusion that summarises the results and their meaning or significance in relation to each objective of the study.

Acknowledgements: Those who contributed to the work but do not meet our authorship criteria should be listed in the Acknowledgments with a description of the contribution. Authors are responsible for ensuring that anyone named in the Acknowledgments agrees to be named.

Also provide the following, each under their own heading:

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- Disclaimer: A statement that the views expressed in the submitted article are his or her own and not an official position of the institution or funder.

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Word limit	3500-7000 words (excluding the structured abstract and references)
Structured abstract	250 words to cover a Background, Aim, Setting, Methods, Results and Conclusion
References	60 or less
Tables/Figures	no more than 7 Tables/Figure
Ethical statement	should be included in the manuscript
Compulsory supplementary file	ethical clearance letter/certificate
Language	only manuscripts presented in English or French will be considered

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File format
The document uploaded during Step 2 of the submission process:

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- **Rich Text Format (RTF)**: Users of other word processing packages should save or convert their files to RTF before uploading. Many free tools are available that will make this process easier.
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