# *Mphil Development Studies*

University of Cape Town

**Research Title:**

**Migrant women's access to public health care services in Makhado, Limpopo: A case of Zimbabwean women**

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**Declaration/Preface**

This work has not been previously submitted in part for a Masters degree, for the award of the MPhil Development Studies degree except where acknowledgements indicate otherwise. It is my own work.

Signature: Signed by candidate                    Date: 15/12/2019

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## Abbreviations

**CEO**: Chief Executive officer

**DHA**: Department of Home Affairs

**FG**- Focus Group

**JRS**: Jesuit Refugee Services

**$P_1$:** Participant 1

**$P_2$:** Participant 2

**$P_3$:** Participant 3

**$P_4$:** Participant 4

**$P_5$:** Participant 5

**WEF:** World Economic Forum

**SADC:** South African Democratic Countries

**SAPS**: South African Police Services

**UN**: United Nations

## Definition of key concepts

**Migrants**- In this study, migrants refer to Zimbabweans who are residing in South Africa. It mainly focuses on the black Zimbabwean women who have been identified as being in a vulnerable state.

**Public health care facilities**- These are the Makhado health facilities such as the Louis Trichardt Memorial Hospital and Louis Trichardt clinic which are fee-free and governed by the state.

**Push factors**- Factors that have led to people migrating from their home country, including unemployment, inadequate health care facilities, and political instability.

**Pull factors**- Factors which would usually attract people to migrate to South Africa, including better access to quality health care facilities, employment opportunities.

**Undocumented migrants**- Migrants who are residing in South Africa without valid documents as prescribed by the South African Department of Home Affairs and the Immigration policies.

**Citizenship**- An individual who is recognized under the South African law to be a legal member of the country (and in this case, it refers to people who are born and residing in South African).

**Zimbabwean migrants:** Participants in this study from Zimbabweans who are residing in Makhado, South Africa.

# Abstract

Migrant women are often omitted within the migrant discourse/research, with that in mind, the research study brings to the fore migrant women's experiences when accessing public health care services within underdeveloped communities. The study explored Zimbabwean migrant women's experiences in accessing public health care services in Makhado, a small town based in Limpopo, South Africa which has only two public health care services namely, Louis Trichardt Memorial Hospital and Louis Trichardt clinic. To conduct this study, ethical clearance was obtained in November 2018 from the Department of Sociology at the University of Cape Town. The qualitative research method was adopted in collecting the data. The study conducted in-depth interviews with five Zimbabwean migrant women who had made use of the two public health care services in Makhado. Field notes, diary entry, an impromptu focus group were used to collect the study data. The sample for the study was purposively selected. The study worked with a total of twelve participants, in-depth interviews with five Zimbabwean women, and a focus group with seven health care workers. The collected data was manually transcribed and was analyzed using the framework analysis. Main themes and sub-themes were extracted from the transcribed interview scripts. The study revealed that migrants accessing the two hospitals in Makhado faced challenges such as language barriers, discrimination, and adverse health personnel attitudes based on the patient's citizenship status. Furthermore, the challenges that nurses are faced within their workplace, which include lack of resources, absenteeism, long working hours and overcrowded public health care services within their workplace contributed towards their negative attitude in assisting patients.

As a result, migrants bore the challenges faced by the nurses within the public health care services. Therefore, the migrants reverted to having other alternatives such as traditional healers, churches, connections with nurses working in the hospitals, private hospitals and over the counter medication.

However, participants underscored that in order for betterment within the public health care services, the following measures ought to be implemented, these include the introduction of independent centres, an increase of mobile clinics, increased number of interpreters, better working environment for the health personnel within the public health care facilities and intensive education training of the health personnel around the awareness migrant issues when accessing public health care services. Foucault's (1980) theory on power and knowledge, played a significant role in

understanding the operational systems of public health care services. It also assisted in understanding how public health care services function, to exclude and control migrant patients, through the introduction of fees and required documentation to access public health care services.

**Keywords:** migration, Zimbabwean women, public health care services, Louis Trichardt Memorial Hospital and Louis Trichardt clinic.

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# Chapter One: Study background, literature and theoretical framework

## SCOPE OF THE STUDY/RESEARCH OUTLINE

### 1.1 Scope of the study

Ban Ki-moon (2013), secretary-general (2007- 2016) of The United Nations (UN) describes migration as an expression of the human aspiration for dignity, safety, and a better future. He further states that it is part of the social fabric, part of our very make-up as a human family. The World Economic Forum (WEF) (2017) recognized that the notion of migration as a global phenomenon with the movement of people both within nations and internationally across boundaries. With the movement host country is affected in terms of equally providing services to all the population. South Africa as a host country (Crush and Tawodzera, 2016), is perceived as one of the countries with a success story to tell when it comes to human rights protection and better access to health service in Sub-Saharan Africa, especially in the post-apartheid era. However, black migrants from the continent are perceived to be depriving the locals of resources, jobs and are deemed to be 'wasting' the state's resources (in health and education sectors).

Furthermore, migrants have come under criticism by the South African Minister of Health Dr Aaron Motsoaledi who termed them as a burden to the public health care services resulting in depletion of hospital resources that are meant for South African patients who utilize the same services. Many South Africans continue to show hostility towards African immigrants through discrimination and anti-migrant labels such as *amakwerekwere*[1] as explained in Crush (2008).

For instance, Tshifhiwa Mukwevho (2018) labelled the hospital Louis Trichardt Memorial as the **"HOSPITAL OF SHAME",** following the case of Ms Sophie Magadani (65) who according to the family was mistreated within the hospital after she was involved in a car accident. The same hospital turned her away when she came for her regular check-up routine, citing that she should make use of the hospital closer to her. These are some of the incidents of how the patients are treated within the public health care services in South Africa. So much has been written in the

[1] Makwerekwere is a South African derogatory term which is often used to degrade the black African migrants in South Africa. In this study, it is used as an expression for anti-migrants and referring to migrants as lesser human beings.

media with regards to the ill-treatment of patients within the publicly funded health institutions globally. This makes one question: to what extent do migrants get treated within these public health care services if the health personnel staff mistreats South African citizens themselves. Do migrants have access to their constitutionally enshrined rights to access publicly funded healthcare? This study explores the question of migrants' access to publicly funded healthcare by looking at Zimbabwean women's access to health services in Makhado, Limpopo.

## 1.2 Study background

The study was motivated by the researcher's Honors research titled, "*Exploring the experiences of Zimbabwean Women Street Vendors in Makhado, Limpopo*". Participants within the study cited ill-treatment from ordinary South Africans and the South African Police Services as a significant problem in successfully running their informal businesses. Furthermore, the participants expressed the challenges that they had in accessing the public services due to their status of being a migrant; these public services included banks and hospitals.

In her stay within different provinces, the researcher had been exposed to various public health care services experiences (Groote Schuur Hospital, Louis Trichardt Memorial Hospital, Louis Trichardt clinic, to name a few). The experiences (including overcrowding, slow attendance from the health personnel, the languages used) sparked an interest to investigate further the treatment of migrant women in South African public hospital services. In one instance, while at the clinic (Louis Trichardt), the researcher was seated next to migrant women who happened to be from Zimbabwe. They were all deliberating in their language chi Shona, with her fundamental understanding of chi Shona, the researcher could understand the deliberation was related to sharing a collective and similar experience that they had encountered within the public health care system in South Africa.

With so many questions in mind, the researcher could not interfere in their deliberation but rather listen more and observe to validate these 'claims'. When one of the ladies' name was called out by the nurse to come to the consultation room, a few remarks were made by the nurse to one of the patients who was Venda speaking about the lady *"havha vhathu vhasokodadza zvibhadela zwashu vhayi mahayani avho hangei sedi" translated* (these people they just come here and fill our hospitals, why don't they go back to their country). All this was happening in Tshivenda

(perhaps in the anticipation that the lady in question would not understand what was being said about her). However, the other Zimbabwean ladies also commented in their language after the remarks made by the nurse *'Nhamo ndiyo inoita tirarame tichidai'* (Poverty is the main reason we must live like this). After all this experience, this motivated the researcher to further investigate and understand the Zimbabwean migrant women's experiences within the public health care system. Besides, Louis Trichardt has become a home for many Zimbabwean migrants since it is closer to Zimbabwe. It has become one of the cities where immigrants, especially in the township called Tshikota, which offers low housing rents, are located and settled.

### 1.2.1 Aim of the Study

This study aims to understand Zimbabwean migrant women's experiences when accessing public health care services in Makhado Limpopo.

### 1.2.2 Study Objectives

To understand Zimbabwean migrant women experiences in accessing public health care services. The study further aims to uncover alternatives and recommendations to the challenges that migrant women are faced with in accessing public health care services.

## 1.3 Literature review and theoretical framework

### 1.3.1 Migration background

In South Africa migration has contributed immensely towards history and economy. During the apartheid era in South Africa, many migrated to fend for their families, and most were divided according to the tribe or skin colour. However, authors such as Reed (2013) argue that due to the apartheid government censoring the data about the black population, the currently existing knowledge about historical patterns of black migration within South Africa is incomplete. Furthermore, it has been noted that during apartheid, migration for the black population (men) was done for a short period and involuntarily, as they were only needed for manual labour in the farms. Donato and Gabaccia (2016) point out that the bulk of the literature paints a picture of migration as a male activity. Men migrate in search of opportunities in neighbouring countries or urban areas. The reality, however, is that women have been and continue to migrate, especially from developing countries to developed countries, as indicated by Sassen (2003). Women in this era migrate for various reasons such as economic opportunities and economic freedom through this, women have become more independent, Adepoju 2011; Sassen 2003; Batisai 2016). Some studies have identified migration by women as a source of emancipation from restrictive cultural and gender norms (Hawkesworth, 2006). This is also corroborated by (Dodson, 2000; Muzvidziwa, 2001) who highlight that female migration has resulted in greater economic independence for women. An essential dimension of globalization is the rapid increase in cross-border flows of knowledge, ideas, cultural and media products, and people then women feature prominently in these flows (Czaika and de Haas, 2014).

Since the fall of formal apartheid, South Africa has received an influx of migrants from neighbouring countries such as Malawi, Zimbabwe, and Zambia. This is mainly because South Africa has been perceived to be one of the ‘developed’ country in the SADC (Southern African Development Community) region. This is corroborated by (Mosselson, 2010) who argued that South Africa in the post-apartheid appeared to be more open in providing refuge to those from troubled or unstable countries.

Furthermore, in post-apartheid South Africa, most of the stricter policies regulating migration have been abandoned, which led to more open borders for the neighbouring countries. Similarly, Posel (2003:16) as cited in Kalitanyi and Visser (2010:384), state that migration into the new South Africa has drastically increased, particularly as the economic and political conditions in neighbouring African countries deteriorate. South Africa is therefore perceived as one of the most progressive among African countries with better economic and stable environments and a safe home for many. This includes job security, access to health care services and political stability.

However, most of the population who migrate are those who are economically active, who are usually between the ages of 25-34 years of age. This population leaves the elderly back home to take care of the children, while they actively take part in the economy. Due to the conditions that many migrants find themselves in, in their host countries such as poor living environments, unhealthy working environments which results to their health becoming more prone to diseases. Many find themselves migration to receive better access to health care, as indicated previously, South Africa then becomes one of the countries with better or improved health care system.

### 1.3.2 South African citizens' perceptions of migrants

South Africans' perceptions about migrants and refugees are linked to social ills such as unemployment and poverty, amongst others. Immigrants are regarded as negatively affecting the health and welfare sectors of the country by consuming already depleted services. Hence some South Africans feel that immigrants contribute to the depletion of state resources exclusively meant for citizens (Evans,1995). Immigrants have been blamed for the increasing incidents of crime and prostitution within South Africa. Crush and Tawodzera (2014), highlight that most of the South African population hold negative perceptions regarding migrants due to these circulating and untrue myths about migrants being the ones spreading the diseases and misusing the South African citizen's resources. These sentiments have heightened the challenges that migrants and refugees face in South Africa. There is a limited effort by the South African state to curb the manifestation of these challenges in the form of xenophobia (Institute for Security Studies and African Center for Migration and Society, 2014).

Many South African state officials seem to be in denial about the existence of xenophobia, with others conveying messages and statements which incite violence (Crush and Tawodzera, 2014). This has led to the general view among most South Africans, that migrants especially black migrants to be seen as the 'other' and not considered to be part of South Africa. This view has led to migrants being viewed as individuals who are waiting to consume the South African citizen's resources.

### 1.3.2 Reasons for leaving Zimbabwe

The challenges that are faced by many Zimbabwean populations were once in the centre of the Zimbabwean elected government in the 1980s post-independence. A study that was conducted by (Mutambanengwe,2012) in Pietermaritzburg on understanding 'Post-migration experiences of Zimbabweans in Pietermaritzburg, South Africa' indicated that there were various reasons that led to people migrating. These reasons can be best grouped into two: Pull and Push factors. Push factors referring to factors that drive people to migrate; one of such factors that have been identified by (Idemudia et al. 2013) is the lack of health care and medication. Pull factors referring to factors that attract migrants in a host country which include better access to health services. (Idemudia et al. 2013) argued in their article that the main reason there was increased migration among Zimbabweans due to lack of access to health care services, especially around the 2000s. This was derived from the study which they conducted 'Migration challenges among Zimbabwean refugees before, during and post-arrival in South Africa'. The below table elaborates in detail the categories and definitions of why some Zimbabwean migrants move to South Africa:

| [2]Push Factors | Pull Factors |
|---|---|
| Deteriorating public health care services | Better/potential access to health services |
| Poverty | Potential of greater/better wealth |
| Unemployment | Better/potential access to job opportunities |
| Drought/starvation | Better/potential access to food |
| Political Instability Education | Political stability Better access to quality education |

[2] The table above does not fully represent the factors that contribute to migration. The above pointed out that pull and push factors are continually changing and are not entirely fixed. Therefore, this table should be taken as an example of some of the factors that possibly contribute to migration. It is best acknowledged that there are different ways of understanding migration depending on the study that one wishes to carry out, which go way beyond the above factors of migration.

### 1.3.4 The Zimbabwean economic instability

The Zimbabwean political and economic instability has significantly affected women's access to public health care services, with negative consequences for maternal mortality rates. In the immediate post-independence period (around 1980s), the Zimbabwean state prioritized universal public health care. The government aimed to redress the inequalities that had existed by race, location and class (Matshalaga, 2000). Zimbabwe defines access to healthcare as the ability to physically reach health care services such as hospitals and receive services in keeping with one's income. Matshalaga (2000), states that Zimbabwean healthcare services started deteriorating in the early 1990s. This further resulted in many paying heavily to access health services and medication. Many Zimbabweans who fall under the low class were therefore profoundly affected as they could not afford the medical fees and were profoundly affected by the scarcity of medication. Due to deteriorating economy, most Zimbabweans (especially those who could not afford to pay for their legal travel documents) took the most dangerous and unsafe routes to migrate to South Africa in search of better access to various services. These routes included border jumping (which includes crossing the Limpopo river), which is infested with crocodiles and robbers.

### 1.3.5 Deteriorating public health care services in Zimbabwe

The economic crisis in Zimbabwe led to the introduction of user fees within the public health care facilities, which according to (Matshalaga, 2000) led to a decline in the outpatient attendance by 18% and a decline in the average length of stay of inpatients by 29%. (Matshalaga,2000), further highlights that the public healthcare services (hospitals) sometimes ran out of medicines. Therefore, they were unable to provide quality care to patients. (Matshalaga, 2000), in his study, revealed that the challenges that the public hospitals faced resulted in the pregnant women being told to bring their own medical equipment and things such as food and bedding.

The deterioration of the Zimbabwean health sector was also accompanied by poverty and rising unemployment rate, which is related to the general economic stagnation. Many people abandoned Zimbabwe due to issues related to poor health care services, high unemployment, poverty and political instability which are also named, push factors, (Crush and Tawodzera, 2016).

Most of the medical workers migrated to countries such as South Africa where they earned better and where their qualifications are recognized (Tevera and Chikanda, 2000). South Africa, therefore, became a haven for many Zimbabweans fleeing from the challenges mentioned above. The participants in (Ross and Chekero, 2008) study indicated that they were motivated to come to South Africa for better access to health services and employment opportunities. However, it must be noted that as many came to South Africa for 'greener pastures', for some, it has not been the case as they face double the tragedy in accessing public health care services in South Africa and it has been challenging to find employment.

### 1.3.6 Poverty as a motivation to migrate

Poverty is one of the significant challenges the Zimbabwean population faces. Several authors such as Machamire (2015) have written extensive newspaper articles on the level of poverty in Zimbabwe, where so many people are living under extreme poverty with areas such as Nkayi in Matabeleland with about 96% poverty levels, Harare 36.4%, and Bulawayo 37.2%. The stagnant economic growth and unemployment rates have contributed immensely to the poverty levels in Zimbabwe. So many people have resorted to migration to escape the poverty crisis. Machamire (2015) had indicated that the period of 2013 when ZANU-PF won the disputed elections, poverty levels worsened with some companies shutting down and hundreds of jobs being lost.

This contradicted with the ZANU-PF's initial plan to eradicate poverty and improve access to health care services for those who were previously disadvantaged, as many people were falling victims of the mentioned social ills. Lack of employment opportunities in deteriorating Zimbabwe contributed hugely to the levels of poverty, which may not be able to afford necessities. Thus, to overcome these challenges, many have opted to migrate to nearby countries such as South Africa to seek better living conditions and employment opportunities.

## 1.4 South African health care system

### 1.4.1 Background of migration policies within the South African context

South Africa may be regarded as one of the most progressive countries when it comes to policies and resources, although the migration policies often tend to infringe migrants' access to public health services (Benjamin, 2019). The South African white paper of Section 25(1) of the immigration, Acts states that a permanent residence holder has all the rights, duties and privileges of a South African citizen as stated in the Immigration Act, 2002 (Act No. 13 of 2002). This is indeed one of the endless ways to ensure migrants are protected on paper. However, reality shows that one's place of birth determines the quality of health they will receive or be offered in public health care services.

Not only that, but South Africa is also faced with a challenge of irregular migration[3], Which seems to be causing so much strain on the state resources. According to the Department of Home Affairs EMCS (January 2017), South Africa experiences migration mostly from the neighbouring countries such as Zimbabwe (21%) and Lesotho (23%), respectively. South Africa has been hit with irregular migration, where most migrants do not have the legal documents that enable them to be in the country, as such the Department of Home Affairs has been faced with a crisis of managing the situation.

This has resulted in the budget strain in the DHA, a total number of 369 726 of migrants were deported between January 2012 and December 2016, as indicated in the DHA report of January 2017. However, the data is not so clear whether this number of deportations also involves what is known as a ‘revolving door’[4]

[3] This refers to the movement of people that take place outside the stipulated laws, regulations and countries agreements on regulating the entry and exiting the country.

[4] Revolving door refers to the same person being deported to their country of origin several times.

### 1.5 Migrants access to health services in South Africa

Since post-apartheid South Africa has become a home to many migrants mostly originating from SADC (Southern African Development Community) countries such as Zimbabwe, (Vearey and Modisenyane, 2017) state that migration impacts the South African public health care, with few resources and staff members, many of the migrants in South Africa are mainly dependent on public hospitals and clinics, and this was corroborated by (Mafuwa, 2015) who examined Zimbabwean migrants in Johannesburg. These are centred on 100 000 refugees and about 80 000 asylum seekers in South Africa, which has caused an enormous strain on the medical services and resources (Vearey and Modisenyane, 2017). This is also taking into consideration that ordinary South Africans use the same services (public clinics and hospitals) as the migrants, as argued in (Mafuwa, 2015). With that said, (Crush and Tawodzera, 2013) have indicated that even the ordinary South African citizens also face similar discrimination from the medical personnel as migrants do. The only difference is that ordinary citizens face discrimination on the type of disease they are being treated for, whereas with migrants it is more intersectional[5].

Many migrant women embark on their journey under unfavourable conditions. Their health and well-being are usually at risk. The difficulty in making a living in a new environment means that migrants are at risk of contracting diseases, mainly sexually transmitted diseases as they deal with the everyday stressors (Ross and Chekero, 2018). In the study done by Vearey and Modisenyane, (2017) they underscore the importance of South Africa's obligation to cater for the well-being and health of migrants as adopted in the World Health Assembly in 2008. The obligation imposes a responsibility on medical care professionals to ensure access to healthcare by migrants is of excellent quality similarly, to that of citizens.

Most patients who are not South African citizens usually lack access to private health insurance (as most of them are involved in informal trading) which would enable them to access the private health sector. This is attributed mostly to a variety of reasons: most migrants take up on low paying jobs or jobs which do not offer any health benefits. Often because of such challenges, when

[5] Intersectionality is an analysis framework tool which was established by Kimberle Crenshaw (1981). The theory states that those who are most marginalized in society are those who fall under multiple forms of minority social stratification.

migrants fall sick, they are unable to access quality private health care services. The public hospital then becomes their alternative, as 'they are not required to pay, or it is more affordable', as indicated in (Ross and Chekero, 2018; and Mafuwa, 2015). However, it has come to light that as much as the public health care is more ‘accessible’, migrants are faced with enormous challenges that range from systematic to individual level which results to exclusion within the public health care system.

### 1.6 South African health care policies in the post-apartheid era

South Africa has committed itself in ensuring that everyone has access to public health care services regardless of their citizen, class, nationalities. For example, in IOM (2012) and IOM (2013) certain health care services relating to South Africa are listed as follows: Constitution of South Africa Chapter II, Section 27 “Everyone has the right to access healthcare services including reproductive health.”

National Healthcare Act 2003 Health care professionals or the health establishment may not deny a person emergency medical treatment.

**Patients’ rights charter**: must be obeyed by every hospital and clinic.

According to the 2011 Human Rights Watch Report, South Africa signed the international treaties which require it to satisfy the rights to optimal health care to be provided on a non-discriminatory basis. The UN Committee on Economic Social and Cultural Rights (CESCR) states that asylum seekers and undocumented migrants must have similar rights health as citizens. Therefore, access to health should not be denied to any person regardless of whether they hold ‘right’ documents.

In addition to the international obligations, the South African Constitution of 1996 (Section 27(1a), Act 108 of 1996) states that every human being has the right to access health care services, including reproductive health care services. However, studies have highlighted that this is not the reality in many South African public hospitals. Ross and Chekero (2018) state that ‘having papers’ can determine one’s access to health care services in South Africa. This is because based on South African migration rules, they (people with papers) are entitled to the same health care services as South Africans, while those without papers (who are staying in the country illegally) have limited access to the public health services. Possession of documentation as an immigrant in South Africa is not a guarantee of having access to social services such as public healthcare. This was evident

in the study that was conducted by (Ross and Chekero, 2018) in Giyani, which revealed that regardless of the possession of documentation, the status of being an immigrant determines the quality of care and attention that one will get from the medical personnel within the public health care services.

### 1.7 Nurses working condition in public health care services in South Africa

The American Nurses Association of 2013 indicates that nursing activities include activities such as protection, promotion, improving the health and abilities of patients. To achieve the suggested activities, nurses should have a sense of wisdom, compassion, sensitivity, and care (Rudolfsson and Beggren, 2012). In post-apartheid South Africa, it was recognized that nurses are critical in terms of functioning and the development of public health care. As indicated by Rispel (2015), nurses in South Africa make up the largest single group of health providers and their role in promoting health and essential health services. However, for nurses to provide the best health care for both patients and society, specific resources need to be in place. Rispel (2015) has indicated that South Africa is faced by the nurse's crisis which is attributed to a shortage of resources within the health sectors and bureaucratic challenges. These challenges, in turn, affect the experiences of many patients within the health care system.

In a study by (Haskins et al. 2010) titled 'Attitudes of nurses towards patient care at the rural district hospital in KwaZulu-Natal Province of South Africa'. Most nurses underscored that they chose nursing as a career to improve people's health, especially in public hospitals, after having their own experiences with the public hospital. In as much as some nurses indicated that the main reason, they chose nursing as a career was due to financial restrictions, they, however, became passionate about the career. Most participants in the study indicated that they are started to dislike the job due to challenges that they faced which in turn affected their attitudes towards patients. The health personnel participants within (Haskins *et al*. 2014) mentioned that the challenges they faced mostly results in most nurses releasing their frustrations on patients.

Furthermore, nurses within the study also mentioned that the challenges that are most frustrating within their working environment are the lack of resources, services, staff absenteeism. Nurses also mentioned that they are mostly required to work with limited or no pieces of equipment, such

as medication for patients. This, in turn, results in migrants being on the receiving end of the nurse's frustration. For nurses, it is an act of coping mechanism towards the injustices and challenges that they are faced with in their workspace or environment.

### 1.8 Challenges that migrant encounter in accessing public health care services

The challenges that migrants face with accessing public health care services can be classified as follows:

| [6]**Push Factors** | **Pull Factors** |
|---|---|
| Barriers to public health care at the migrant level | Economic Local languages |
| Personnel Attitudes | Negative perceptions of migrants |
| Enabling Resources | Immigration status |
| System Level | Medical Xenophobia South Africa government restrictions (policies and laws) |

#### 1.8.1 Impact of Local languages within public health care services

Remaining in South Africa as a migrant is a daunting task for many, as "regular check[s] for documents and linguistic capabilities … are a regular part of the migrant experience" (Ross and Chekero, 2018:43). Migrants are confronted with hostile attitudes from hospital officials and locals who are often anti-migrant. In the study done by (Ross and Chekero,2018) most migrants, especially women, reported having been discriminated against by the medical staff who speak to them in Tshivenda, Tsonga, and Sepedi - the significant languages of the area. The study indicated that many of the migrants did not understand the languages that the health personnel used, and there was no translation accorded. This has become a challenge for many migrants with regards to accessing public health care services. Benjamini (2019) revealed that many medical professionals (including the front desk personnel) use their home language in communicating with patients. IOM (2006), states that language is frequently cited as a significant obstacle to the use of health and social services for migrants. As a result, the lack of language skills can be a significant barrier for

[6] The table above does not fully represent the factors that contribute to migration. The above pointed out that pull and push factors are continually changing and are not entirely fixed. Therefore, this table should be taken as an example of some of the factors that possibly contribute to migration. It is best acknowledged that there are different ways of understanding migration depending on the study that one wishes to carry out, which go way beyond the above factors of migration.

many migrants to understand the bureaucratic procedures and functioning of the health system in South Africa. As indicated in (Ross and Chekero, 2018), many South African hospitals lack services such as translation which makes it difficult for many migrants to express their concerns and needs within the public health care system.

### 1.8.2 Health Personnel attitudes towards patients

A study conducted by (Mafuwa, 2015) depicts medical personnel in South Africa as xenophobic and anti-immigrant. Similarly, a study that was conducted by (Ojwang et al. 2010) in Kenya 'Nurses impoliteness as an impediment to patients' rights in selected Kenyan hospitals' patients complained about the nurse's negative attitudes, rudeness and stripping patients of their dignity. More so, most of the personnel attitude has been 'violation of patients' rights through verbal abuse' (Ojwang et al., 2010:4). As much as the hospital is meant to care and save the patients' lives or perhaps empower the patients, it has since become a space where patients are deprived of their freedom of movement, association, and self-determination (Ojwang et al. 2010) due to how the medical personnel treats the patients. Cross border migrants are generally viewed as placing an unnecessary burden on all social services in general and public health care systems is one of them (Worth, 2006).

Racial and cultural discrimination towards immigrants acts as a barrier in accessing health care services. Vearey (2010), explains that most SADC countries deport irregular or undocumented migrants, among them, based on a 2014 study are diagnosed with non- communicable diseases such as diabetes and hypertension. That makes it difficult for undocumented migrants to access public health care services. Vearey and Ritcher (2008) write that irregular or undocumented migrants may encounter unique vulnerabilities such as fear of deportation if they show themselves at health care centres for health service. Thus, Ross and Chekero (2018) discovered that many migrants are reliant on traditional medicines and private doctors as an alternative to public health care services.

However, the study by (Ross and Chekero, 2018) found that the negative attitudes of the nurses are not only directed to migrants, but South African citizens as well are subjected to the same hostility. Similarly, so, a case of a 24-year-old Johannesburg woman who lost her child at the Edenvale Hospital due to the negligence of the health personnel, "She did not get the help and

support she needed from the hospital staff" (Health24, 2016). This story alone tells of the gruesome experiences that patients making use of the public hospitals are faced with in daily basis.

### 1.8.3 Citizenship

Migrants experience challenges within the public health care services, which are mainly associated with their status as non-nationals. In an interview with Janine Kakusheta in 2016, who is a home-based care worker at the Johannesburg Branch of Jesuit Refugee Services (JRS)[7]Highlights that when she took a patient into one of the public hospitals around Johannesburg, who according to the interview, was suffering from kidney failure. The doctors were reluctant to attend to the patient as they argued that "he does not have a green identity document, therefore does not qualify for the medical assistance" Janine Kakusheta (2012). As a result of the denial of service in the public health care cause of citizenship, the patient in question, unfortunately, passed on. This took place regardless of the National Health Act, which stipulates that foreign nationals (patients) without any documentation or permits shall not be denied emergency medical treatment. These experiences indeed prove how the issue of citizenship plays a considerable role in determining one's access to public health care services.

However, literature has shown that it is not only migrant citizens who are mistreated due to being a non-national in South Africa. Besides, the exclusion that South Africans are experiencing based on Ms Magadani case relate to structures (service area) that govern the provision of health care. From this observation, the issue of exclusion within the public health care services does not only depend on one's citizenship status.

## 1.9 Theoretical framework: Foucault (1980) Power

The theoretical framework of this study was based on Foucault's (1980) theory on power and its ability to explain the everyday practices of power between people (patients) and institutions (for this study, institutions refer to hospitals and clinics and nurses). Foucault (1980) asserts that power is more of a strategy than a possession; it is co-extensive with resistance as a productive factor because it has positive effects such as the individual's self-making.

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[7] Jesuit Refugee Services is an international organization which aims to accompany, serve and advocate for refugees and asylum seekers in South Africa within the health care system.

As such, a condition of possibility for any relation is its ubiquitous, being found in any type of relationship between members of society. Foucault's (1980) theory was more preferred for this study because of its ability to explain everyday practices on provision and accessing of public health care between the Zimbabwean immigrant women patients and public health care institutions to illuminate the different positions that individuals and institutions occupy in the provision and accessing of public health care.

Foucault’s (1980) exploration of power was crucial in unpacking and explaining the experiences and challenges that Zimbabwean immigrant women encounter when accessing public health care services in Makhado. Foucault’s (1980) work was very significant in exposing the presentation and abuse of power by the health care personnel and the actual functioning of power in accessing or failure to access public health care services by Zimbabwean migrant women. More so, Foucault’s (1980) theory was very significant for this study, given that medical personnel have the power to determine people who can access the health care services and have this idea that if one is a migrant, they are obliged to pay to receive any medical assistance.

Thus, this theory was essential in examining the relationship between the medical/ health practitioner and migrant patients. The views by Foucault can be attributed to the experiences of the immigrant patients who must conform to the requirements of medical institutions to be granted access to services. Based on Foucault’s (1980b) ideology, hospitals hold specific mechanisms and techniques which are employed by the health personnel that provides public health care to control all the patients that make use of their services including additional mechanism and technique that were used for an immigrant population that resulted in them experiencing barriers in accessing public health care. These techniques include documentation, stipulating that everyone who requires to make use of the hospital must produce documents such as identity documents. Thus, both citizens and migrants must conform to this in order to receive assistance.

To a certain extent, the same disciplinary measures that are implemented by the hospitals; patients always find a way to resist the disciplinary measures (Foucault, 1977). The resistance is done through producing the same documents that the hospital has put in place to access the hospital resources. Also, the oppressive behaviour of the health or medical personnel has led to migrants

finding alternatives in taking care of their well-being. These include making use of private hospitals instead of public health care services. This shows that any oppressive measures that are put in place are faced with a specific form of resistance from the migrants.

### 1.10 Conclusion

The chapter explored the challenges that migrants are faced with globally when accessing public health care services. The literature explored was more relevant to the three main objectives of the study namely: access to public health care services, migrant women experiences when accessing public health care services and lastly the coping mechanisms employed by migrant women. Furthermore, to understand the dynamics within the public health care sector, Foucault theory was essential in explaining the abuse of power by many health care personnel. As a result, health care personnel can control who can access services through either documentation or discrimination. The literature has also revealed that within the South African context, many migrants' rights are violated and infringed. The literature has also revealed that most of the South African public health care sectors have gone against the treaties that South Africa signed in terms of providing quality health care for migrants. The challenges explored within the literature will be further explored in the below chapters, which will cover in detail Zimbabwean migrant women experiences within the public health care system in Makhado.

## Chapter Outline

### Chapter two

The study aimed to uncover the Zimbabwean migrant women's experiences in accessing the public health care services in Makhado. To understand this, the study adopted a qualitative research methodology. This section focused on the methodology that was used in collecting the data around the experiences of Zimbabwean migrant women's experiences in accessing public health care services in Makhado. It also focused on the process of the data collection and the analysis of the data regarding the research question. This chapter introduced the personal experience of the researcher, which played a considerable role in detailing the experiences of patients when accessing public health care services. It also elaborated on the procedures that the patients underwent before receiving treatment. This section aimed to answer objective one of the studies, which they would inform the experiences of migrant women, which will be discussed in other chapters.

### Chapter Three

This chapter focused on exploring the experiences of Zimbabwean migrant women when accessing the two public health care services in Makhado. These experiences included: the impact of the language barrier on migrants when they sought to access the public health care services. The chapter also explored the relations between migrant patients and health personnel within public health care services. More so, the chapter explored the impact of the lack of resources within the public health care services has on how nurses relate with patients.

### Chapter Four

This chapter focused on the alternatives and solutions to the challenges that migrants are faced with in accessing the public health care services. These alternatives and solutions were extracted from Zimbabwean migrant participant's interview scripts and the researcher's recommendations. In the interviews conducted with the Zimbabwean migrant women, most of them highlighted that they had to find other alternatives from the public health care services, to avoid being stripped of their dignity. This was mainly because of the treatment they experienced within the public health care services in Makhado. To ensure that they are well attended to and treated of whatever sickness

or health challenges they are facing, participants mentioned that they have had to opt for the following channels.

**Chapter Five**

This chapter summarised the overall conclusions and findings. This chapter also outlined the study shortfalls and possible future research areas and the strengths of the study. The chapter also consists of the overall study conclusion and the study disclaimer, which states that the participants transcribed transcripts will not be shared with anyone or made part of the study, this is due to the agreement that the researcher had with the participants.

# CHAPTER TWO

## MIGRANTS ACCESS TO PUBLIC HEALTH CARE SERVICES IN MAKHADO

### 2.0 Introduction

This chapter focuses on migrant women access to public health care services in Makhado. It firstly gives the background of the research setting and the methods that were used in collecting the data. After that, the chapter outlines the requirements that are needed for one to access public health care services based on participants' experiences.

### 2.1 Methods:

#### 2.1.1 Research Setting

The research was conducted in Makhado which is also known as (Louis Trichardt) in Limpopo, in a small community called Tshikota. Makhado lies at the foot of Songozwi Mountains and is 90 minutes' drive from the Zimbabwean border in Beitbridge. It falls under the Vhembe District, and it operates under the Vhembe District Municipalities.

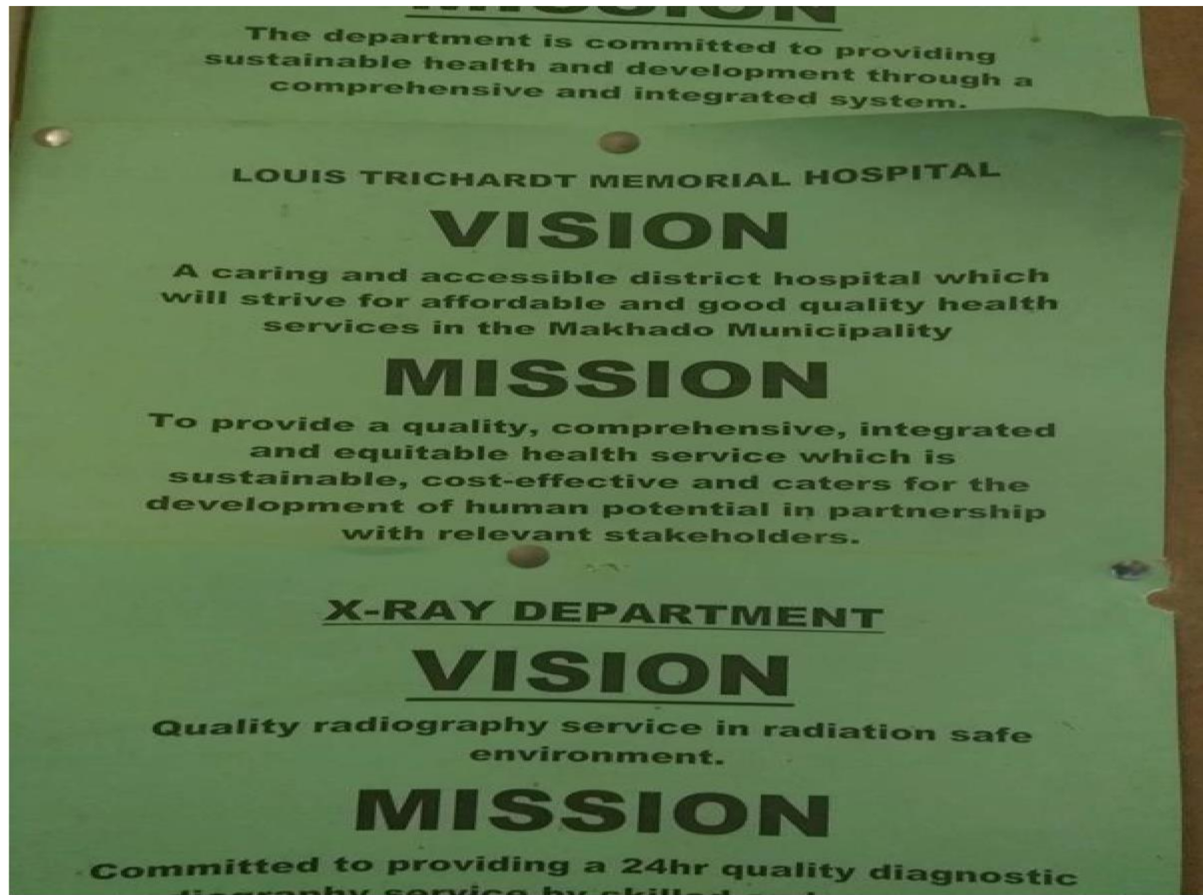
Makhado has limited public health care facilities as it consists of one public hospital (Louis Trichardt Memorial Hospital) and one primary public health care clinic (Louis Trichardt Clinic) which serves a population of around 25 360 as per Census 2011. Louis Trichardt is close to the Beit-Bridge-South Africa border, the hospital and clinic are more likely to serve more than the number as mentioned above, it was very insightful to see how migrant women are treated within the public health care services.

**Source**: https://www.worldatlas.com/af/za/lp/where-is-louis-trichardt.html

As shown on the map above, Makhado (Louis Trichardt is quite close to the Zimbabwean border. According to Census 2011, Makhado accommodates about 54.11% of females, with about 97.3% black African population. It is also a community with 68% Tshivenda speaking population (which makes the language a dominant one).

### 2.1.2 Louis Trichardt Memorial Hospital

Louis Trichardt Memorial hospital is one of the biggest hospitals in the Limpopo province, which falls under the provincial government and Vhembe District hospitals. It is also a hospital that serves patients from Makhado and other surrounding communities and many migrants.




***Source: Picture was taken by the researcher (27 December 2018)***

At the right side of the Louis Trichardt Memorial Hospital entrance, a board with different posts relating to the rules, rights and different types of diseases stand. However, what stood out was the Louis Trichardt Memorial Hospital vision which speaks to the values and principles of the hospital. Additionally, at the main entrance of Louis Trichardt Memorial Hospitals, stands a large board which shows the operating times and visiting times of the hospital. One is immediately met by a security guard who controls the movement of people who access the hospital through a register and verification of identity documents of all the visitors (including those coming in with cars).

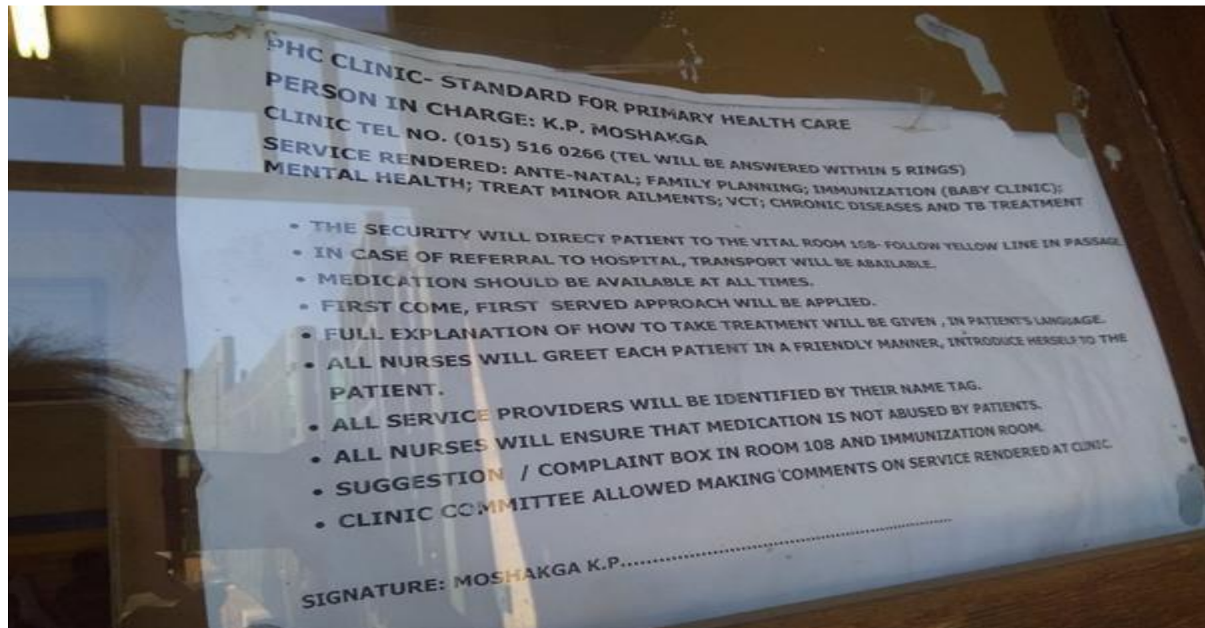
***Source: Picture was taken by the researcher on the 27 December 2018 during a visit to the Louis Trichardt Memorial Hospital***

### 2.1.3 Louis Trichardt clinic

Louis Trichardt Clinic is a public primary health care facility located in Makhado central. It is the first point of call for many patients before they get referred to the hospital. At the entrance of the clinic, within the reception area, there is a security guard who is responsible for registering all the incoming patients and answering queries to the visitors. At the reception area, there is a board that shows the estimated waiting period for each patient within the clinic and instructions that each patient must follow.

However, what stood out was point number five in a poster which states that "**FULL EXPLANATION OF HOW TO TAKE TREATMENT WILL BE GIVEN, IN PATIENT'S**

**LANGUAGE".** This was of importance for the data analysis, and it also resonated with the participant's responses during the interviews, as many mentioned that the language issue was the biggest challenge they faced within the clinic, where nurses and including the frontline staff communicated in Tshivenda yet not in every patient's language.




***Source: The above picture was taken by the researcher on the 23 December 2018 at Louis Trichardt Clinic***

### 2.1.4 Research Design

To answer the main research question, the study was guided by the qualitative research method. A qualitative research method is mainly characterized by its aims which relate to understanding some aspects of social life (Quinn and Cochran, 2002). Thus, the research project aimed to understand the perspectives of both Zimbabwean migrant women and health personnel participants and it also explored the meanings that the participants attached to public health care phenomena. The qualitative research method also helped in answering the 'what question'.

Furthermore, qualitative studies allowed the researcher to interact with participants as they explored and attempted to make sense of their social world (Babbie & Mouton, 2001:270) and particular social phenomena from the perspective of targeted participants (Bless and Higson-Smith et al., 2013:16). A qualitative study was more suitable for this study in mapping out the feelings

and thoughts of the participants relating to accessing public health care services. Babbie & Mouton (2001) mention that qualitative methods are flexible, Thus, this method became more imperative as it enabled participants to share in detail their experiences relating to their experiences with the public health care services. This method was also useful as it gave room for other important issues relating to the experiences of Zimbabwean women accessing public health care services to unfold.

Similarly, (Patton, 2002) mentions qualitative data are in-depth descriptions of circumstances, people, interactions, observed behaviours, events, attitudes, thoughts and beliefs and direct quotes from people who experience or are experiencing the phenomena. The issues included understanding how Zimbabwean women usually adapted to the South African environment as much as it is not something that was much related to the health issue. Furthermore, qualitative research method enabled participants to express the solutions that they believe would be suitable for their needs and ensure that they receive quality health care.

### 2.1.5 Study Population

For this study, purposive sampling was employed, which is also referred to as non-probability sampling. Through purposive sampling, the researcher was able to reach out to the targeted population of Zimbabwean migrant women who had experience with public health care in Makhado. The main reason for purposive sampling in the study was because the researcher wanted to generate in-depth, rich data from a small sample. Etikan et al. (2016) relay that in purposive sampling, the participants should have the ability to communicate experiences and opinions in an articulate, expressive and reflective manner.

Therefore, participants selected were able to provide and share rich information and had the most significant insights on the research question, based on their experiences within the public health care and having served the migrants, women, within the public health care services. For the whole research project, purposive sampling was the primary sampling technique.

Furthermore, only Zimbabwean women who had experience with the local public health care facilities were utilized for the study, and the inclusion criteria was a better command of the English language. Due to limited access to participants, the report adopted the snowballing technique,

which is also known as a chain referral technique. The snowballing sampling technique method was used when characteristics to be possessed by participants which were rare and difficult to find. Since the researcher only knew two Zimbabwean women, it was a challenge to access more participants. However, using snowballing, the leading participant who was $P_1$ was much helpful in referring me to fellow Zimbabwean women who have had experience in using public health care services in Makhado.

Before going to the field, the researcher had a set number of participants laid out. However, while in the field it all became unpredictable and was able to work with five Zimbabwean women who resided in Makhado and who have used both the Louis Trichardt Memorial Hospital and Louis Trichardt clinic. Furthermore, the issue of the focus group was initially not part of my study; however, from an informal focus group, the information shared was fruitful for the study. Therefore, to get information on the nurses, the researcher worked with an informal focus group of health care personnel within the community, who helped shed light on the challenges they are faced with in hospital and the perceptions they hold towards the Zimbabwean migrant women utilizing the public hospitals in Makhado. Overall, twelve participants were utilized for the study.

#### 2.1.6 Participant recruitment and enrolment

##### 2.1.6.1 Nurses

On the day of the 'interview' (23 December 2018 at 15:03), the researcher interacted with one of the nurses who reside within Makhado and who happened to be health personnel within the Louis Trichardt clinic. During the interaction, the researcher and the participant in question we're joined by four more ladies who also happened to be nurses in Louis Trichardt Clinic and Louis Trichardt Memorial Hospital. The discussion was centred on migrant women and the utilization of the public health care services from their point of view.

However, because of the way the discussion was set, the researcher could not engage the participants in detail with regards to their identity. This would have seemed like a threat to their jobs. For the sake of understanding their thoughts without imposing any risks to their jobs, all the conversations were carried out in front of the researcher's homestead, for approximately one and a half hours.

#### 2.1.6.2 Migrant women

The semi-structured interviews for migrant participants were piloted before they were used for the interviews. The researcher set up a time and venue for everyone who took part in the study. The research topic was explained to every participant before they could the consent form; participants were also given a copy of the consent form.  Participants rights were explained had concerning the interview processes. Each participant was also given an information sheet which had the researcher's details and the purposes of the study. All migrant women participants who took part in the study were from a low economic, social class. The interviews were set for one hour for each participant, and the participants were also informed that the interview would be voluntary and that there is no remuneration for participating. All the interviews were conducted in English.

## 2.2 Study measures:

### 2.2.1 In-depth Interviews

The data was collected through face-to-face interviews with Zimbabwean migrant women and health personnel participants. The date and time, as well as suitable locations, were arranged with each participant to conduct semi-structured interviews, especially with the migrant participants as their participation was well planned. Semi-structured interviews with open-ended questions were used. According to Ritchie and Lewis (2003), In-depth interviews are the most suitable data collection technique, especially if the study is more about mining information surrounding participants' perceptions, experiences, feelings, and opinions. The main reason the study adopted the open-ended questions was to enable participants to provide as much detail and depth as they may wish to give and to capture much of the voices of the women with regards to their challenges in the public hospitals. The initial interview questions were piloted twice to study peers and my supervisor before carrying officially carrying out the interview process with the participants. This was to allow the researcher an opportunity to refine the research questions in preparation for the interviews. The semi-structured interview scripts for Zimbabwean migrant women participants had the following statements as guides for the participants:

### 2.2.2 Experiences in accessing public hospitals

- Use of public health care services
- Experience of public healthcare services
- Quality of care received and attention

### 2.2.3 Barriers to accessing public hospitals

- What documents are required for one to access health services?
- What services are provided/available in the health services in ensuring that migrants access quality treatment?
- Languages that are used by the medical staff?
- Attitudes of the medical personnel towards migrant patients?
- What are other alternatives to public health care?

### 2.2.4 Impromptu Participant Observations

The study also utilized the participant observation method, which was at Louis Trichardt Memorial Hospital and Louis Trichardt clinic, in an impromptu manner. In the first visit to the Louis Trichardt Clinic, the researcher went as a patient; Purposefully, the researcher used her phone as a notebook to write down all the observations and activities that were related to the research topic.

According to Marshall and Rossman (1989), study observation refers to a systematic description of events, behaviours, and artefacts in the social setting which was chosen for a study (which in this case would be Louis Trichardt Memorial Hospital and Tshikota Clinic). Furthermore, McLeod (2015) states that with participant observation, the researcher joins in and becomes part of the group they are studying. Regarding the research, the researcher had gone to public health care services in Makhado as a patient who also gave her a glimpse and an understanding of what patients usually must go through in the public medical institutions. As such, the researcher took the route covert[8] observation, as indicated in (McLeod,2015), the study was carried out 'undercover'. In realization of the activities taking place, the researcher decided to remain the

[8] Covert Observation is the kind of observation whereby the identity of the researcher and the nature of the study are not disclosed. This kind of observation, allows participants to act and live natural within their habitat, without any interference

patient and did not disclose her interests to anyone on the activities taking place. The main reason for being 'undercover' was to ensure that the real experiences of the migrant patients were recorded.

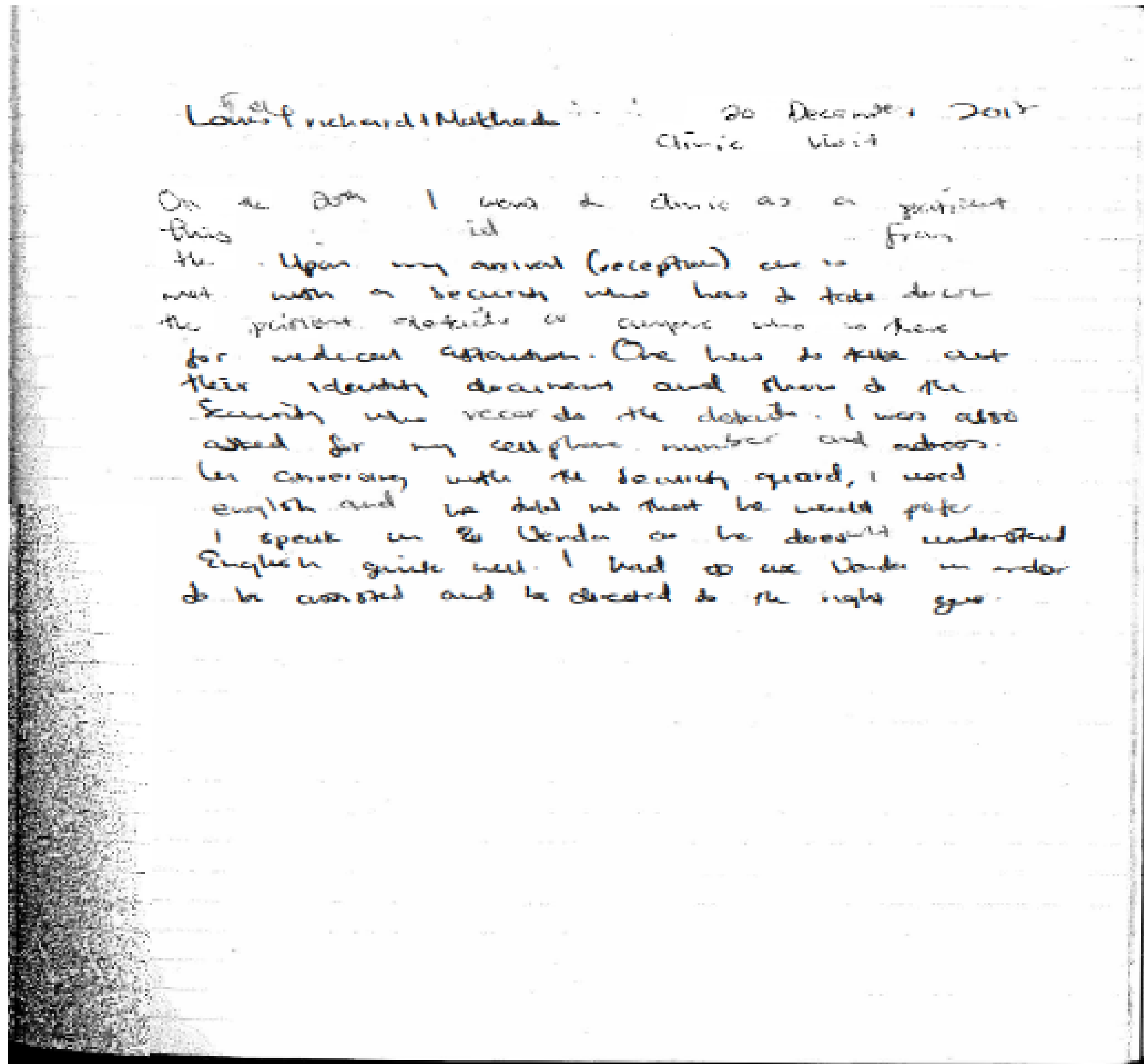
### 2.2.5 Field Notes and impromptu focus group discussion

While in the fieldwork, with an idea of not disrupting the usual daily activities of the participants, the researcher ensured that she scribbled notes on the observations and interactions of the participants (especially in the hospital and clinic where she was being attended to as a patient). According to Emmerson et al. (2001), field notes are not only about facts but also a way of reflecting and serving a particular purpose.

Throughout her hospital and clinic visit, the researcher carried with her a small notebook (this is a routine, wherever she went). However, there were some moments where the researcher was not able to make use of the notebook as it would become evident to participants. The writings would detail the minute the researcher walked into the hospital or clinic, the processes that each patient had to follow, the interaction between nurses and patients and their colleagues, the conversations that patients would have and the hospital environments (for some she would record, and for some, she took pictures of the hospital surrounding[9]). Every activity that would contribute towards the research study was recorded, in agreement with the actions that were carried out by the researcher Phillipi and Lauderdale (2018) have stated that field notes created a record of the study unfolding over time and are exceedingly valuable in the research analysis stage.

A cell phone was used to record all the activities which took place (which would, later, be transferred to the researcher's fieldwork research book) and some questions to probe for the in-depth interviews with the participants. Permission to use the data and information being shared during the interaction was obtained from the participants verbally. All the participants agreed, however, were not comfortable to be recorded. The use of field notes was then helpful in recording such, "those short notes can help remember important aspects for creation of detailed field notes following interaction" (Phillipi and Lauderdale, 2018:385)

[9] Permission to take photographs from the hospital environment was obtained from the front desk staff of the hospital and clinic



***Source: An extract from the researcher's notebook***

## 2.2.6 Diary Entry

A diary became one of the most useful tools during the data collection. The researcher would have a moment they would reflect on the events that happened during the day, and this was done in line with Phillipi and Lauderdale (2018) who state as a researcher after every pertinent detail of the interview, one should spend a few moments intentionally reflecting on the whole of the interview process and reflect on their performance. A diary became a place where the researcher could express her feelings and fears concerning the research process. The diary served a great purpose in analyzing the data through using some of the contents and activities that took place in that day, similarly to the arguments made by Phillipi and Lauderdale (2018) indicating the importance of

short notes in remembering some of the critical aspects that took place during the interview process.

## 2.3 Study Ethical Considerations

According to Resnik (2015), the most common way of defining ethics is distinguishing between acceptable and unacceptable behaviour through/within the research process. In thinking about this research, the researcher had to ensure that many accept of the research process were considered. Asking a person to talk about their experiences (where they were maybe frightened, humiliated and pained) might cause some level of anxiety and may force the person to relive the trauma. This was what the researcher experienced within my data collection period, where emotions were expressed when the participants were narrating their stories with regards to their experiences with accessing public health care services. Capron (1989) indicates that any kind of research should be guided by the principles of respect for people and justice. This includes the participants' rights to be informed in detail about the study and what their participation entails. Therefore, to ensure that the ideas Capron (1989) were adhered to, the researcher ensured that the intensity of the questions or the topic to the participants was explained to participants before the interview, this was a way of preparing them beforehand on the intensity of the research.

Furthermore, the researcher had to create a relationship of trust with the participants coming from different backgrounds. The researcher and the participants were able to get to know each other. This technique yielded positive results as we were able to get to know each other, and some 'friendships' were established, and most of the participants seemed to be comfortable around during the interview process. For the research project, consent was prioritized since it deals with sensitive issues. Kvale (1996) states that informed consent honours qualitative research study principle. This was done by ensuring that everyone who participated in the study does so out of his or her own free will, without being unfairly pressured into it or by any act of deception and or inducement. Thus, the participants were well informed about what their participation entails within the study and declining to partake in the study would not affect them in any way. Consent was also obtained through verbal (especially on the nurses and the hospital health personnel staff) and written forms which were completed by the Zimbabwean women who took part in the study. This is because sometimes written consent may be frightening to the participants, which was the case with the nurses and health personnel staff in fear of losing their jobs.

The issue of confidentiality and anonymity was applied throughout the study. This was done through ensuring that all the participants were informed that their identity would be withheld using pseudo names in writing up my report. Orb et al. (2001) state that the uses of pseudonyms are highly recommended when one is researching on a sensitive topic. Thus, to ensure confidentiality, the devices containing the data were protected with a password which was only known to me as the researcher. Furthermore, in collecting data, permission to use the data for study purposes was obtained, this was to ensure that participants were aware of where the data will be used. More so, Orb et al. (2001) argue that participants should be informed on how the results will be published or shared.

To honour this, participants were informed that the results of the study would be shared with the supervisor and external examiners, and there is a possibility of publishing the work. Participants were also informed that the transcripts would not be shared with any other person; instead, specific quotes will be extracted and used within the study. Permission to record the interviews was obtained from all the participants in several ways which included verbal and written. To avoid bridging the research ethics, all participants were above the age of 18 years, meaning they could give consent on their own.

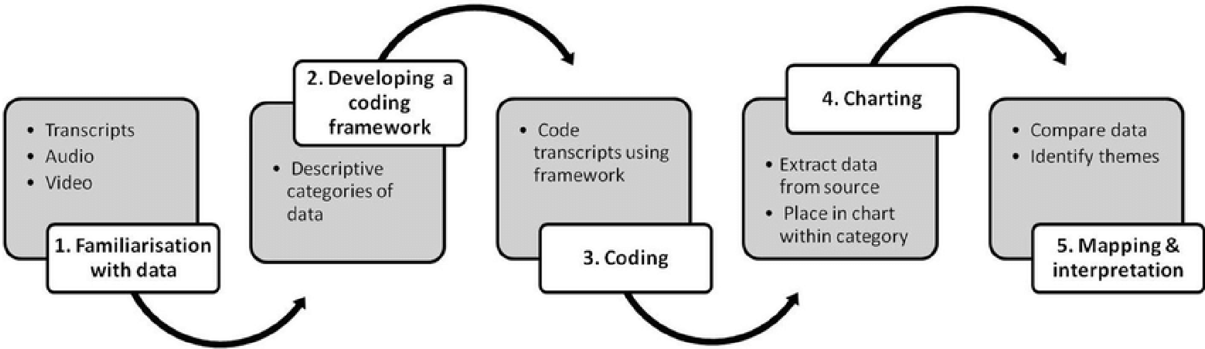
Lastly, the research proposal was presented to the Sociology Department on the 21/11/2018 and obtained the ethical clearance from the department to proceed with the study end of November 2018, see attached appendix E.

### 2.4 Data Analysis

Recorded interviews that were collected from the participants were manually transcribed using headphones to listen to them and type word for word. The transcribing of the recordings as the researcher realized that as a researcher, there were some things that the researcher may remember what happened during the interview process. Therefore, the researcher was able to make a note of them and refer to them when analysing the data. The transcribed data were analysed using the Ritchie and Spencer (1994), the five-step process of the framework analysis. The framework analysis was most preferred for data analysis, as "it provides systematic and visible stages to the

analysis process...can be clear about the stages by which the results have been obtained" (Lacey and Luff, 2001:13).

The study aimed to present the experiences of Zimbabwean women; framework analysis was suitable as it also allowed "for the inclusion of prior as well as emergent concepts" (Lacey and Luff, 2001:13). In general, the framework analysis was less restrictive in terms of exploring and sorting out the data. The analysis of the study was done following the Ritchie and Spencer (1994) framework analysis five stages, as shown below:




**Source: Ritchie and Spencer (1994) Five-step process in Framework analysis**

The five-step by Ritchie and Spencer (1994) helped guide the study data analysis. The first step in the data analysis was going back to the research question, which would act as a clear guide on what needs to be achieved. In analysing the data, the research objectives and the research questions were used as a guide. The following Ritchie and Spencer (1994) framework analysis process, the following stages were employed as discussed below:

According to Ritchie and Spencer (1994), familiarization with data refers to the process where a researcher becomes more familiar with the transcripts of the data collected. Since the researcher conducted the interviews, the researcher became more familiar with the information or data during the process of the interviews. According to Ritchie and Spencer (1994), this stage involves the process of designing and testing a coding framework to capture data with relevance to the research

questions. At this stage, coding categories are pragmatic, rather than interpretive. For example, deliberately broad level extraction of the data: factors influencing the migration". During this stage, the main research question was revisited while understanding the data. This was to ensure that the collected data was answering the main research question. For this stage, the researcher went over the transcribed data and listened to the audio recordings in understanding the voices of the participants. This was useful in identifying the recurring patterns within the data and making notes which would involve listening to recorded audios and reading the transcripts while noting any recurring patterns within the raw data and transcribed data. All the transcripts were coded, where themes were grouped, with sub-themes. This was done by ensuring that the researcher goes through the transcripts and highlighting the information that may relate to a similar point. Different colours for coding were established to make it easier to classify the points. Coding portions of tests were extracted from the transcribed interview transcripts and collated together in a chart. Under the mapping and interpretation stage; the inductive process of thematic comparison and analysis common to many qualitative approaches adhered to, and the chart had three columns.

### 2.4.1 Availability of the full interview scripts

The transcribed transcripts for this study will not be published or shared with anyone. This is mainly because the scripts contain some of the individual names and sensitive information which were mentioned during the interviews. In following the ethics that were put out to the participants, the researcher has decided to withhold the transcripts to protect the identity of the participants.

## 2.5 Discussion and findings

### 2.5.1 Researchers personal reflection

On 20 December, I went to the Louis Trichardt clinic to attend to a minor illness that I was experiencing. This was also during the period where I was conducting interviews for the study. When I went to the clinic, at reception, I encountered a security guard who acted as front desk personnel. Just like every other patient, we were required to record our details which included address, contact details and ID number. After one completes these details, they are then given a small card which has a number and then proceeds to join the queue. However, what was more appalling, was the language challenge that I encountered with the security guard, who insisted that he does not understand English and therefore prefers communicating in Tshivenda. Although I was at a much-privileged position since I am a Tshivenda speaking South African citizen, it made me reflect the challenges that migrants who do not understand the official language used in the clinic, encounter daily. All this process made me reflect on the challenges faced by many who utilize the public health care system.

### 2.5.2 Payment

In accessing public health care services, certain documents are required. All participants mentioned that the front desk hospital would need a document to open a folder for each participant. Asked if the participants were required to make payments, all the participants mentioned that they did not have to make any payments within the public health care services in Makhado. Hence so many migrants prefer using the public hospital as they are not required to pay for it.

*"No, we did not pay it was actually for free and all"(P$_1$)*

*"I think because most of them know that they do not have to pay to be helped, we having a lot of them coming here which is overburdening the hospital" (Focus group)*

*"Oh no they do not have to pay it is a free service for everyone regardless whether they are from South Africa or migrants" (Focus group)*

The study that was conducted by Mafuwa (2015) in Cape Town found that about 23% of migrants who made use of the public health care services in Johannesburg were required to pay a medical fee, with some participants indicating that they were required to pay around R100-R150. However,

the health personnel who took part in the study mentioned that sometimes South African citizens as well are required to make payments in the public health care, but it all depends on the type of treatment, but they are not charged the same amounts as the migrant patients. As much as the Zimbabwean migrant participants who took part in the study indicated that they had not paid to access public health care, the nurse's participants mentioned that:

*"Sometimes patients are required to pay a little bit of money especially those who will be having surgery, but for minor consultation and treatment they do not have to pay"(Focus group)*

Mafuwa (2015) argued that many migrants hesitate to access or make use of public health care services due to the payments that they must make. Taking into consideration many of the migrant's economic status, paying to access medical services becomes an added burden to migrants. This also resonates with the arguments made by (Matshalaga, 2000) who have argued that many people from low class find it challenging to access public health care. Therefore, one's economic status should factor in before the hospital could ask them to pay. Paying for medical access becomes a barrier for many migrant patients and South African citizen patients. One can further argue that the issue of economic class determines one's ability to access public health care services.

### 2.5.3 Passport or ID Document

Zimbabwean participants who took part in the study mentioned that upon arrival in the hospital, a passport or identity document was requested by the security guard stationed at the gate or reception. The information would then be recorded in a booklet, which acts as a hospital register for all patients. The passport or identity document seemed useful in opening a patient folder and registering a patient.

However, none of the Zimbabwean migrant's participants who took part in the study indicated that they were denied access to public health care services due to lack of documentation, this then is in line with the National Health Care Act of 2003 which stipulates that foreign nationals without any documentation or permits shall not be denied emergency medical treatment. Instead, one of the participants mentioned that they know of someone who was denied access due to lack of documentation in the same health care services that they have used.

*"ID but I told them that I lost my passport, so I completed this other form by the security, and they asked if I had some form of identification and I showed them my Zimbabwean ID, and they allowed me to go through. So, when you get to the front, you just open the folder and fill in certain information there and then you will be called out to see a nurse"($P_4$)*

However, the above statement is in contrast with the findings of Ross and Chekero (2018) who in their study found that the lack of documentation means the denial of access to medical health services in Giyani. They also found that documentation is used as an identifier of the kind of treatment that patients would receive. This resonates with the arguments that were made Foucault's (1980) on of power and how institutions use their power in implementing laws that oppress people. One realizes that documentation is used as a tool to determine and control the treatment that migrants would receive from the public health care services. In support of the arguments made by (Foucault, 1980) authors such as (Afro-velcamp, 2017) argue that the legal framework plays a huge role in limiting migrants' access to health care services through the requirement of legal documentation. Vearey and Ritcher (2016), have also argued that most migrants, especially undocumented, may encounter unique vulnerabilities such as fear of deportation if they show themselves at the public health care services.

*"I go to church because I do not have the papers to go to the hospital. It is next to the police station so they will deport me" P3*

### 2.5.4 Address and contact details

Participant's mentioned that upon arrival in both the hospital and clinic, they were asked for their contact details (which was mostly the mobile number) and their residential addresses. These were also used for the opening of the patient file. Therefore, every patient, including the South African citizen patients, are required to provide such information before they could consult with a nurse or doctor, they are to complete a booklet and the requested details.

*"They also asked for my address, like where I stay here in South Africa" ($P_1$)*

However, the study found that most migrants would provide the front desk or security staff with incorrect addresses. This is mainly because most participants did not have a designated home

address, as most stayed in the informal settlement. The lack of address did not seem to be a significant issue for participants to access public health care. This was visible when some migrant participants mentioned that they would inform the front desk staff:

> *"I am just coming from Zimbabwe, and I do not stay here, I am just here to see the doctor. So, I just ask if they want my Zimbabwean address, and they will just say "it is okay"(P$_4$)*

As much as participants highlighted that they were not denied access due to lack of address, migrant participants also mentioned that it is one of the reasons that most migrants will be pushed away and more hesitant to utilize the public health care system. More so, participants in the study highlighted that the main reason they could not provide their home address, especially undocumented ones is due to the fear of being deported. This was also much prevalent in the study conducted by Ross and Chekero (2018), where participants mentioned that usually, the hospitals work hand in hand with the Department of Home Affairs. Therefore, providing the correct address to the health personnel or front desk staff places them in the danger of being ambushed by the Department of Home Affairs alongside the South African Police Services.

These were the shared sentiments with the participants who took part in the study by (Ross and Chekero, 2018), where participants mentioned that they fear using the public hospitals (especially those who do not own the legal documents) as they work hand in hand with the SAPS and Home Affairs. They also mentioned that the government officials are making use of the public health care services in arresting the undocumented migrants and deporting them. Thus, for many, they feel that public health care services are a trap for many, and it is a service that is avoided by many migrants.

However, this was not the case as presented by the health personnel participants in the study, who mostly mentioned that, the issue of address is of paramount, especially when one would need regular check-ups. The health personnel participants mentioned that the home addresses are then useful to follow up on participants and for regular check-ups from their place of residence. Overall, as much as the requirement of patients having to provide their address may act as a barrier to many migrants accessing public health care, it is also of great use in reducing the illness within the communities.

### 2.5.5 Hospital patient file

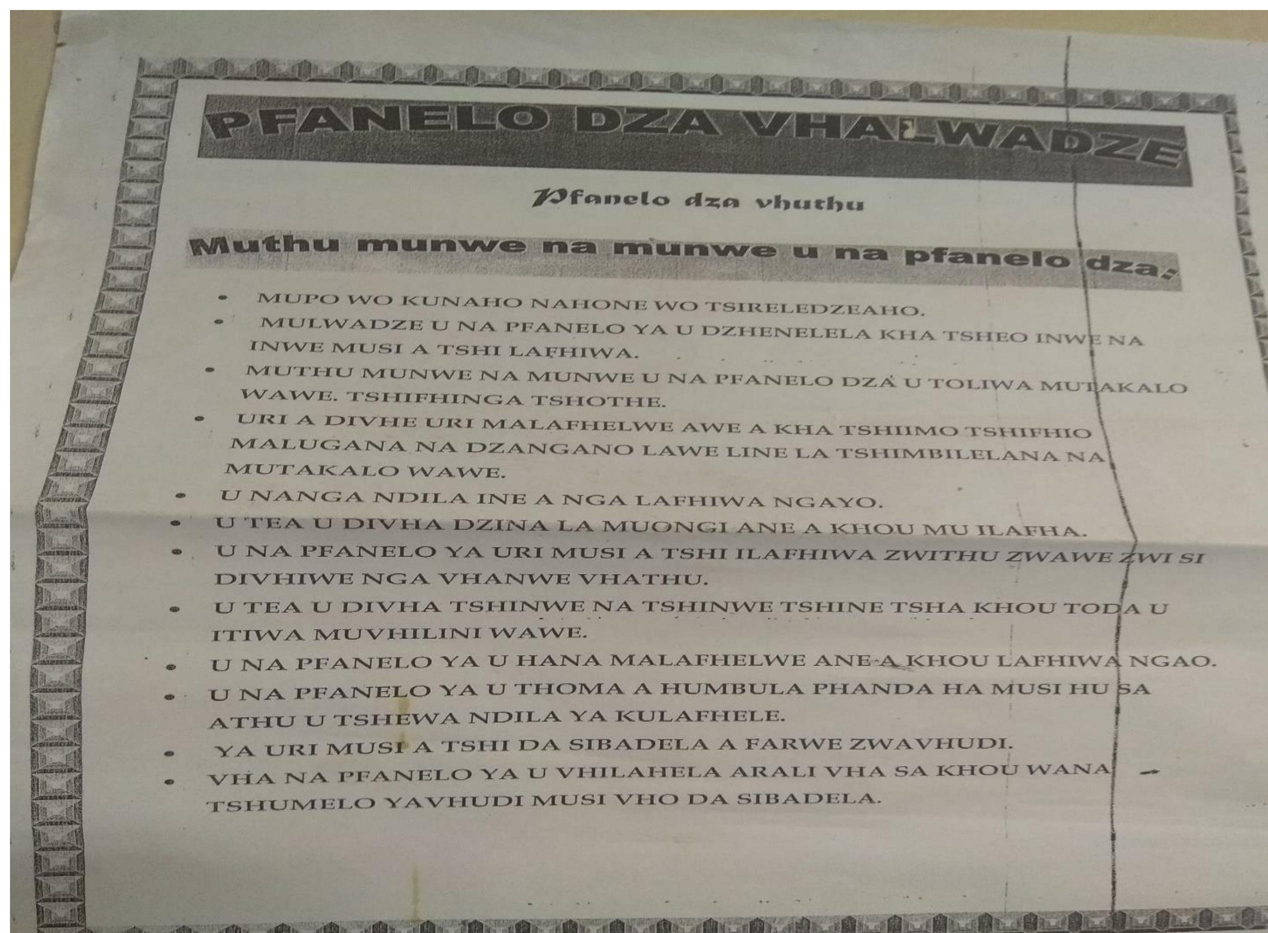
During the interviews, most Zimbabwean participants kept emphasizing the hospital file. Upon probing further, participants mentioned that the above information is also a requirement for the hospital file. They also indicated that the hospital file for every patient contains all their personal and very private information (the type of sickness, prescriptions and any other health-related matters). Many participants understood this procedure; however, one of the participants highlighted that:

> *"I just feel that receptionists should not access our files, because they open them, and as soon as they see what you are suffering from, they start looking at you badly or like disgusted. It is like my life is just put out for everyone" ($P_4$)*

This goes to show that sometimes patients are not discriminated only based on their citizenship but also based on the kind of illness that they have. Some participants also mentioned, a receptionist at the public hospital probes very personal information:

> *"like the lady who works in front she asked me what I was there for, and other people were sitting, so I ended up lying why I was there. You cannot be asking me such personal information in front of people. Cause I thought maybe I just need to explain to the doctor what is wrong with me" ($P_3$)*

As a result, most migrants find that the public health care services strip them of their dignity. The article by Ndivhuwo (2017) who have named the Louis Trichardt Memorial Hospital as a "HOSPITAL OF SHAME" then explains the challenges that are faced by patients when accessing the health services in public hospitals. Due to such gruesome treatment that migrant patients are exposed to within the public health care services, most of them have come to avoid the hospital at all costs. The complaints raised by the participants, go against one of their rights which were mentioned in one of the posters within the Louis Trichardt Memorial Hospital, which mentions that "***UNA PFANELO YA URI MUSI A TSHI ILAFHIWA ZWITHU ZWAWE ZWI SI DIVHIWE NGA VHANGWE VHATHU"*** (Every patient has got the right to privacy). However, the study found that the right that the hospital mentions, is the same right that is being violated within the public health care services premises. This also explains the difficulties that patients, in general, are facing within the public health care services.




***Source: picture taken by the researcher at the Louis Trichardt Memorial Hospital***

## 2.6 Conclusion

This chapter has discussed the requirements that are required at the entry point of public health care services in Makhado as the main barrier for migrants. The requirements also act as a system to determine the kind of treatment that the individual would receive based on the documentation that they produce. Although the study found that most participants were never asked to pay a fee at a public hospital in Makhado, some mentioned that they knew of other migrant patients who were required to pay.

This was supported by the health care personnel participant, who argued that the main reason other migrant patient had to pay was due to the intensity of the treatment. The issue of payment in Ross and Chekero (2018) and Mafuwa (2015) findings was presented as a huge factor that prevents most migrants from accessing public health care services, taking into consideration the economic

conditions of many migrants. The findings on the two studies were contrasted to the participant's reason for not using the public health care services, payment was not a massive factor for many, but the fear of being deported was more prevalent. Not only that, but the study also found out that the relationships that migrants have created with South African citizens were beneficial for them to access the public services as one mentioned that:

*"I am fortunate, my neighbour assists me with some information or documents that I may need" ($P_3$)*

Furthermore, this study found that it is not only migrant patients who are subjected to the requirements of producing documentation but instead, South African patients as well are required to follow the same procedure. The difference, as mentioned by the health personnel participants is that South Africans can produce an affidavit which has their identity number, unlike migrants who:

*"Sometimes provide the hospital with incorrect information, and it is difficult to verify their documentation" (Focus group)*

The theory of Foucault (1980) played a huge role in understanding the operational systems of public health care services. It also assisted in understanding how public health care services function, to exclude and control migrant patients, through the introduction of fees and required documentation to access public health care services.

# CHAPTER THREE

## MIGRANT WOMEN EXPERIENCES IN ACCESSING PUBLIC HEALTH CARE SERVICES IN MAKHADO

### Introduction

The chapter aimed to discuss the relations between migrant patients and health personnel within public health care services. More so, the chapter explored the impact that the lack of resources has within the public health care system and how nurses relate with patients. Overall the chapter aimed to understand:

- Relations between health personnel and migrant patients
- Migrants perceptions about how the health personnel conduct their work in hospitals
- Understanding if migrant patients are treated the same way as the South African citizens by the health personnel?
- The treatment of migrants when accessing public health care services?
- Language doctor's use in communicating with migrants within the public health care services
- Health personnel perceptions of migrant women patients utilizing the two public health care facilities

### 3.1 Findings and discussion

#### 3.1.1 Language complications in communication with hospital personnel

The issue of communication seemed to be much prevalent in all the interviews with all the participants. Migrant participants mentioned that they struggled to communicate with the nurses and front desk staff during the consultation. The study found that the use of Tshivenda was very much prevalent among health care personnel, which makes it difficult for migrant participants to explain the sickness and understand the process they have to follow within the hospital. As much as they attempted to communicate in English, it appeared the hospital front desk staff and nurses were so adamant about using Tshivenda.

*"It is a Venda place, and they all used was Venda starting from the security guard who was helping me" ($P_1$)*

The researcher also noted the above challenge during her visit, as stated previously. The health personnel starting from the security guard at the door, they all used Tshivenda, although the researcher used English to communicate with the health care personnel, and they all responded in Tshivenda. Even though the researcher was at an advantage, as Tshivenda is her home language, she felt the migrants who did not understand the language were being disadvantaged.

"*Was explaining in English and she would respond in Venda. I think maybe that day she was just having a bad day I mean she was not even smiling or anything." ($P_1$)*

Migrant participants further explained that language was one of the major challenges they face when accessing the public health care facilities in Makhado. Various articles such as the IOM (2006), note that language is frequently cited as a significant obstacle for migrants to access public health and social services. As a result, the study found that many migrant participants are struggling to use the medication as prescribed by the health personnel. Migrant patients relied on the instructions written on the medical bottles for instruction on how to take the medication. This is despite the hospital and the clinic indicating that **"FULL EXPLANATION OF HOW TO TAKE TREATMENT WILL BE GIVEN IN PATIENTS LANGUAGE'**. However, most participants indicated that they find themselves relying more on the instructions written on the outer side of the medication bottle. Arguably, this is one of the many mechanisms that have been adopted by the Zimbabwean migrant women to manoeuvre the public health care system.

*"But luckily I could read the package of the pills. Shuuu I remember trying to explain to the doctor what was wrong mixing chiShona and Tshivenda and she was having none of it, so I just pointed where the pain was, and from that time I just became uncomfortable, and I even doubt that they gave me the right medication, cause the pain was not going away. Only if she was patient enough to listen to me, but it just did not happen" ($P_4$)*

*"'Well, to be honest, it was hard at first cause during that time I did not understand the language well. So I was dependent on what they are pointing to and having to see what other people are doing in front of me" ($P_5$)*

This is in line with the ethnographic study that was conducted by (Ross and Chekero, 2018) in Giyani, Limpopo, where Zimbabwean migrants mentioned that the main challenge, they are faced

with in public hospitals is the issue of language. This also did not come as a surprise, in the interviews conducted with health personnel in Makhado, none of them could speak any foreign language. Not only that, but nurses within the study also mentioned that they usually use Tshivenda to communicate with patients, as Tshivenda is a dominant language within the community.

Thus, the assumption would be that anyone residing in the area should be able to speak Tshivenda. As a researcher, the information was a bit alarming, and it also contrasted with the posters that were placed within the Louis Trichardt clinic, as the posters read as the follows "**FULL EXPLANATION OF HOW TO TAKE TREATMENT WILL BE GIVEN IN PATIENTS LANGUAGE**". Patients who have used the two public health care facilities are left to read the instructions on their own, as the nurses fail to explain the instructions to patients who speak different languages from them. This challenge was also noted by the IOM (2006), which stated that language was frequently cited as a major obstacle to the use of health and social services for migrants. Therefore, in the study by Ahluwalia (2016), language skills are then considered to be an essential factor for integration and navigation within the public health care system.

### 3.1.2 Consequences of speaking English with the hospital staff

The participants mentioned that whenever they attempted to communicate with the hospital staff in English, either they were ignored, or the health personnel would probably respond in Venda. This then shows the resistance that the health personnel had in terms of using another language to communicate.

Following the theory of Foucault (1986), most health personnel in public health care services use the issue of language to display their power to patients. For patients to use English, also displays the power that migrants have in resisting the same system that is oppressing them. Foucault (1984) argued that power and oppression do not go unchallenged; usually, the oppressed would find ways to resist the oppression. This was the case for migrants and health personnel within the public health care system. The health personnel mentioned that the main reason they revert to their home language when a patient communicates with them in English is that:

*"I mean I have no problem with someone talking English with me, but mostly I still do not understand their accent which is very frustrating to deal, and when you are frustrated you will use your mother tongue"(Focus group)*

### 3.2 Health Personnel perceptions of migrants' patients

In conversation with the nurses and some hospital staff, it came clear that in interacting with migrants' patients hold individual perceptions. The nurses indicated that it is mostly a challenge attending to a migrant patient due to language barrier. Health care personnel participants were then asked of their perceptions on migrant patients: different perceptions were mentioned as discussed below:

#### 3.2.1 Migrants overburdening the public health care system

Most participants mentioned that they seem to be receiving more migrant patients compared to South Africa citizens. The nurses seemed to be more concerned as they mentioned that most of the resources were meant for South African citizens. However, even those who have been admitted (in-patients) were migrants. Health personnel participants mentioned that the number of migrant patients that they assist had increased drastically; these sentiments were also shared by the then South African Minister of Health Aaron Motsoaledi, who on several occasions was heard mentioning that "migrants are burdening the already crumbling public health care services in South Africa". However, from the interviews conducted, it appeared that the public health care system is already crumbling. Therefore, the problem does not lie with migrants utilizing the services, but rather the South African government and public health care sector failing to adjust to the new reality and failing to address the challenges internally. As a result, migrants are blamed for the already failing public health care system. Some of the health personnel participants mentioned that it becomes a challenge when they must admit (in-patient) a South Africa citizen and only to discover that there is no bed for them, yet a Zimbabwe patient is occupying the bed.

*"Zimbabwean women they overcrowd the spaces in the hospitals, so when one who pays tax arrives at the hospital, and they do not have a bed which is not fair" (Focus group)*

*"But they are just many, and you realize that we are running off the resources and locals do not utilize the resources as much. So they are many, and it is not easy to cater to all of them, and that is why most of the*

*time we end up preferring locals to be treated first, so it is ensuring that the resources are brought back to the locals. So basically resources are not enough for everyone they are not enough" (Focus group)*

Worth (2006), mentioned that cross-border migrants are generally viewed as placing the unnecessary burden on all Southern African social services. Due to such sentiments, it then explains the treatment that many migrants are exposed to in the South African public health care facilities. For example, the story of Theresa Ngwendu, a Zimbabwean national, who was refused medical assistance in the Mamelodi Hospital in Johannesburg and was told "this is not Zimbabwe" (Isaac Mahlangu, 2019).

As a result, Ngwendu lost her child during birth without assistance from the hospital. Although this was an unfortunate situation, it is the reality of many migrants when they are accessing public health care services in South Africa. Although the investigations following the incident indicated that the hospital was faced with challenges such as overcrowding, which was the main factor, they could not assist the patient. Then one has to ask, does the overcrowding of the hospital gives nurse/health personnel a lieu way to communicate with patients in a manner that strips their dignity and humanity. This was no different from the findings of Ojwang et al. (2010), who states that most patients in their study, complained about nurses' negative attitudes, rudeness and stripping patients of their dignity. Based on all the complaints and findings, the South African government should acknowledge that the South African public health care is in crisis, a crisis that is beyond migrants.

### 3.2.2 Migrant women not trustworthy

During the focus group interview, it was revealed that most Zimbabwean migrant patients are not trustworthy. One of the nurses mentioned that whenever a Zimbabwean patient visits the hospital, they change their identity, and they would visit the hospital three times a week suffering from a different illness. Nurses mentioned that this is mostly done in the aid to collect different types of medications which then can be back in Zimbabwe as most of the patients reside around Beitbridge. Nurses mentioned that they are mostly blamed for mistreating Zimbabwean migrant patients. However, the ill-treatment stems from the experiences that they have had with many migrant patients misusing the resources.

This relates to the study that was conducted by Ross and Chekero (2018) mentioned that regardless of migrants possessing legal documentation, the status of being an immigrant determines the quality of care and attention that one will get from the medical personnel within the South African public hospitals. Similarly, (Saburi, 2017) in her study findings, participants mentioned that health personnel were rude and not supportive of them, especially when they discover that they are non-South African citizens.

This then explains the outrage that the migrant participants in the study expressed, about being mistreated within the public hospitals. One of the nurses indeed agreed to the statement mentioned by one Zimbabwean migrant arguing that:

> *"The problem with these women they come to the hospital, for example, to get prevention pills right, which is not a problem, then she will come back again next week with a different name, but you still can recognize the face. You ask yourself where they take the medication to. You should just take a walk around Beitbridge, and you find them selling the medication. It is like we are just supplying the medication for their businesses" (Focus group)*

Although the above act is not condoned, one realizes that selling medication for migrants is a way of survival towards their country's crumbling economy and avoiding being exploited from the work environment in South Africa. This was confirmed by one of the Zimbabwean participants in the study who mentioned that:

> *"you just have to see an opportunity and make use of it for survival, so you will just do what it takes to make sure you feed the family" ($P_3$)*

### 3.2.3 'Citizens versus the Others'

Some of the above discussed perceptions that most health personnel hold against migrant women patients, explain the adverse treatment that migrant women receive within the health care system. Most of the migrant participants expressed dissatisfaction with how both the hospital and clinic operated. The hospital and clinic were accused of neglecting migrant patients. Instead, the participants expressed that the hospital staff would usually assist South African patients compared to migrants. Besides, the participants mentioned that they never felt as though as they were a priority, with one of them stating that:

*"To be honest, it was one the hardest things that one had to go through in these hospitals cause it is not like you are a priority anyway possible to get helped" ($P_2$)*

The above sentiments were also shared within the study that was conducted by Ross and Chekero (2018) in the Giyani area, which found that most participants indicated dissatisfaction with the way health personnel would usually prefer to help South African citizen patients compared to migrant patients. Concerning this, the nurses also confirmed that the main reason they are prioritizing the South African citizens' patients is that:

*"Zimbabwean women overcrowded our spaces in hospitals, so when one person who pays tax arrives at the hospital, and they do not have a bed, it becomes a problem, so it is best to give the bed to the one who is meant to access those resources" (Focus group)*

Vearey and Modisenyane (2017) mentioned that about 100000 refugees and about 80 000 asylum seekers in South Africa had caused an enormous strain on medical services and resources. Although the South African public hospitals are obliged by the South African Constitution of 1996 to provide quality medical services to everyone without discrimination and favouritism. The health personnel in Makhado have failed to provide quality services to the migrants and South African patients, and this is despite migrants not paying for the services, from the data collected it seems they are still treated as the second citizens and not being recognized as a priority. These sentiments are also shared by Ahluwalia (2016), who mentioned that migrants in Dehli are disrespected at the health care services based on their physical appearance and their migrant status. In agreement, Crush and Tawodzera (2014) also mention that migrants are faced with medical xenophobia; this includes the negative attitudes of the health care personnel towards the migrants based on their status.

Based on the data collected, the study uncovered that one of the pressing matters from the Zimbabwean migrant participants is that they felt as though the two hospitals helped the South African citizens first before they could be assisted. Foucault (1980), the theory of knowledge and power, indicates that health personnel has made use of citizenship to exercise power on how they distribute the services to patients, hence the preference of the South African citizens.

*"We went there at 06:00 in the morning, and we waited until 20:00 in the night, waiting for a doctor or a nurse to help us and worst of all these doctors and nurses knew that we have been sitting in the line for a very long time, but they ignored us. Like they would do their gossiping nonsense at the back and tell you that there are not enough nurses today and give excuses. Luckily there was one doctor that felt for us and helped us, and we were so happy, and these nurses kept on giving us this ugly look." ($P_1$)*

*"I have realized here in South Africa if you do not have blood or anything like scratch by you they will not help you." ($P_1$)*

The nurses from the study were a bit defensive on the issue of treating South Africans first compared to migrants. As much as their decisions are sound, this also goes against the international treaties which South Africa signed, which requires South African public hospitals "to satisfy that the rights to optimal health care to be provided on a non-discriminatory basis" (Human Rights Report Watch, 2011:6). Migrants are discriminated against due to their status of being a migrant. Hence, they are not treated as a priority by the health personnel. As a result, in Saburi (2017), the study concluded that the relationship between the health personnel and migrant patients was described as unfavourable, as migrant patients indicated that the health personnel had a negative attitude, rude and uncaring.

The notion of migrants depleting resources is something that does not only stem in South Africa. This often happens in developed countries where the blame is shifted on migrants for any challenge that the country is facing. This seems to refer to both 'legal' and 'illegal' migrants, who are perceived as burdening and misusing the state resources, as indicated in Crush and Tawodzera (2014). Authors such as Androula and Maltezou (2011) have argued that access to public health throughout the European countries is increasingly being used as a weapon in immigration control. Taking into consideration the comments made by the then Minister of Health, Aaron Motsoaledi and the Department of Home Affairs, it would be argued that health care in South Africa has become one of the systems to control migrants.

The study has uncovered that nurses within the public health care services, are too faced with challenges in the work environment, which at the end, affects the quality of work that they must provide to the patients. All the health care participants who were interviewed mentioned that it was not only migrants who had a challenge in accessing quality health care services, but also South African citizens. The nurses and the hospital staff interviewed mentioned that the main challenge

they are faced with is a staff shortage, which in turn affects the productivity of their work. Similar sentiments were shared by Rispel (2015) has indicated that South Africa is faced by the nurses' crisis which is attributed to the shortage of resources within the health sectors and bureaucratic challenges. More so, the health personnel participants indicated that they are faced with limited support from the Department of Health, especially around the issues of equipment and staff shortages. However, in challenges that are faced by health personnel, some nurses carry out their duties excellently, they also go beyond their line of duty in ensuring that the patient's well-being is well-taken care of, this was expressed by one of the participants who mentioned that:

*"Sometimes you look at a patient, and you know so well that there is no medication for their specific illness, and you find yourself searching your bag or calling around to make sure the patient gets the medication"(Focus group)*

### 3.2.4 Time patients spend at the hospital

All the migrant participants expressed that they had to spend more time in the hospital and clinic before they could be assisted. This is regardless of the clinic having a notice on the board indicating that the patient is more likely to wait for 2 hours 15 minutes until they are assisted. However, participants mentioned that they had to wait up until the following day (which is more than 8 hours) to be assisted.

*'Saturday the nurses do not work that much so yeah we went there, so we waited from 06:00 in the morning-20:00 waiting for a nurse' ($P_1$)*

Whereas, some health personnel participants mentioned that your wound or sickness mostly determines the time that one is more likely to spend in the hospital. With one participant mentioning that:

*"With my broken hand because of the queues and the movement of people and also I have realized here in South Africa if you do not have blood or anything like scratch by you they will not help you and you will stay in the line forever"($P_1$)*

More so, the health personnel explained that the main reason patients spend more time waiting for assistance is due to the challenges that they are faced with in their work environment. These challenges include staff shortage, as indicated previously, which has affected the work output. The

picture below explains the challenge that the nurses encounter, and this is a consultation room with worn-out equipment. Such sites explain the slow work progress in the public health care services, and the amount of time that patients must spend in public health care.

Based on the photographs that were taken from the Louis Trichardt Clinic, it is visible that the hospital is operating with the little they have. The triage room, in the clinic, had broken equipment and untidy. It is under such circumstances that nurses are expected to work and deliver their exceptional services to the patients.

***Source: The researcher took the picture above during her visit to the Louis Trichardt Clinic on December 27, 2018)***

Besides, the lack of resources such as shortage of medications in public hospitals which affects their daily operations health personnel indicates that there is extensive corruption among themselves which depletes the State resources.

> *"You will find that those who work in the pharmacy area have access to medication. As much as you will have new stock such as ARV's mostly, they do not get to last. This is because our staff usually steal medication. Do not know whether it is for their benefit or they get to make a profit out of it by selling it at a higher price on the outside" (P6)*

The health personnel participant further referred to a case of theft of medication that took place in 2017 in Polokwane, where two guards who were working for the Department of Health at the time, were arrested with the medication worth R1.2 million. The participant also referred to the article which was written by Riana Joubert published under Review Online February 20, 2017, about the drugs (medication) that were stolen from the Polokwane depot by employees who work within the hospital[10]. In general, the participants mentioned that they find themselves mostly dealing with dishonest employees, and as a result, patients are the ones who get affected the most. All these factors then result in the challenge articulated below:

### 3.2.5 Long queues and slow services

Many of the participants expressed their frustrations along the waiting period that one to be assisted within the hospital. Participants mentioned that often they would have to be absent from work as it may take up the whole day as there are long queues, and the health personnel would usually take their time in assisting the patients.

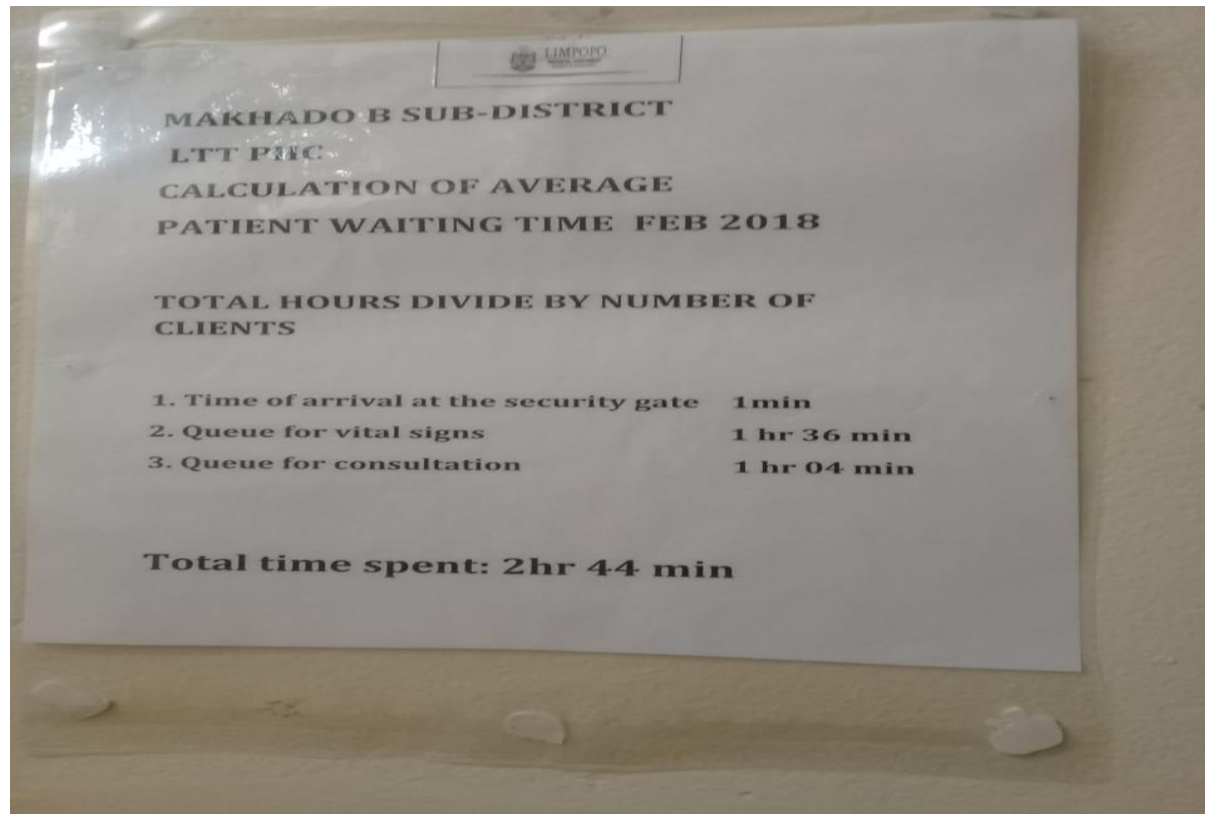
> "*I mean when we went there the queues, I am telling you, so when we went there I was not helped the first day." (P2)*
>
> *"We went there at 06:00 in the morning, and we waited until 20:00 in the night, waiting for a doctor or a nurse to help us and worst of all these doctors and nurses knew that we have been sitting in the line for a very long time, but they ignored us" ($P_1$)*

The issue of long queues also seemed to be raised more often by the nurses. They mentioned that the long queues in the hospitals are more draining, and staff shortage is some of the challenges the hospital is faced with. This is similar to the arguments by Haskins et al. (2010) study nurses indicated that they chose nursing as a career due to the passion they have, but they are starting to dislike the job especially in the public health care services because of financial restrictions, staff shortages and lack of resources, which slows their productivity.

[10] https://reviewonline.co.za/196267/polokwane-guards arrested-medication-worth-r1-2m/

***Source: part of the queues waiting to consult with the nurses. The researcher took the picture during the visit at the Louis Trichardt Clinic (This picture was edited to protect the identity of the patients)***

The observations around the hospitals were mostly supported by the pictures taken during the visits. Most of the people visiting the clinic are more likely to spend more than three hours before they can be assisted. On the other hand, this goes beyond the suggested estimated time by the hospital (as it can be shown below) that one patient must spend within the hospital before they could be assisted.




***Source: picture (showing the estimated time that each patient is more likely to spend within the clinic before they are assisted) was taken at the Louis Trichardt clinic by the researcher.***

### 3.3 Conclusion

This chapter discussed the challenges that migrant women are faced with when accessing the public health care services in Makhado. However, none of the participants indicated that they were denied access due to lack of documentation. Most participants from the study indicated that the major challenge they are faced with the language barrier and negative relations with the health care personnel, where most patients are ill-treated based on their migration status. More so, the study uncovered that ill-treatments are not only faced by migrant patients, but also South African citizen patients go through similar treatment and discrimination.

The study has understood the functioning of the public health care system and health personnel through the lenses of Foucault theory on power and knowledge. The theory was important in unpacking and understanding the migrant patients' experiences within the public health care system. The study has found that lack of resources within the public health care system plays a significant role in the output of many health personnel. What was more appalling within the study, was that none of the health personnel mentioned the impact of not having stable management

within the Louis Trichardt Hospital, which has a negative influence in terms of service delivery. As a result, the productivity of many heath personnel is negatively impacted.

# Chapter Four

## ALTERNATIVES OR COPING MECHANISMS EMPLOYED BY MIGRANT WOMEN

### 4.0 Introduction

With challenges that migrants are faced with in the South African public health care system, many find themselves looking elsewhere for better services. In the study conducted by Ross and Chekero (2018) migrant participants indicated that rather than making use of the public health care they have since resorted to other alternatives, which for them is an act of resistance from the hardships they encounter when accessing public health care facilities. As indicated in some literature such as Crush and Tawodzera (2016), South African public hospitals are brutal towards migrants, and migrants are most discriminated against. As explained in the previous chapter, Zimbabwean migrant women indicated that they are mostly faced with the language barrier as an obstacle to access public health care services in Makhado successfully. Thus, to protect their dignity, migrants have had to look for other alternatives. This chapter then aimed to:

- Explore the alternatives that migrant women have in place in accessing health care
- Recommendations to the challenges faced by migrants

## 4.1 Findings and discussions

### 4.1.1 Churches

Most participants mentioned that they have become more dependent on the church (where pastors can pray for them). Some mentioned that they do not pay for prayers in church. Hence a lot of Zimbabwean migrants have decided to take on the route of going to church. With some saying that after they are informed of their illnesses or life problems, they often receive assistance in solving the problems.

During the interview, P2, who is part of the *masowe* church, share the pride in the help that they receive in church, as she said:

*She had been going to the hospital because of her ill son. She mentioned that she spent the little money to take her son to the private doctors to determine what could be wrong with her son, and that did not yield positive results. As part of the masowe[11] church, and due to lack of funds, the last option was to take her son to church. She mentioned that during the church service, the prophet called them aside, and they were informed of what is causing her son's illness and that the hospitals would not have been able to detect the illness, but only the holy spirit. She mentioned that she was given munato to give her son. She mentioned that it only took two days, and she could see changes in her son's health. She also mentioned that the son has since recovered fully. She mentioned that mostly she would instead make use of the church, where she will be informed whether she may need the hospital.*

The above statement shows that for some patients, church has become a coping mechanism in dealing with the medical xenophobia and discrimination that they are faced with when accessing public health care services. Puchalski (2001) mentioned that spiritual patients might utilize their beliefs in coping with illness, pain and life stresses.

*"Cause in the church it becomes free, and you get to hear about all the life problems hey and then you will know what is happening in your life, even if someone prophesizes you in Tshivenda, there is always someone who will explain to you what the prophet is saying, and then after that they just prepare munamoto for you"($P_2$)*

*"You might go there for days without even being attended to so rather have other alternatives like let me go to church for them to pray for me rather than using that Memorial Hospital and that clinic" ($P_3$)*

The participants also mentioned that church is a place where they not only seek healing but also create relations with the South African citizens. The participants further mentioned that the relations formed with South African citizens are very vital for their survival in South Africa. Through these relations, they learn the South African cultures and access the public services that they are not able to access on their own such as banks.

[11] Masowe is an African church which was founded after the Zimbabwean preacher and priest Johanne Mosowe

In summary, the study revealed that a church for many migrants is not only for healing purposes but a place where they can create relations with the South African citizens. Migrants use the relations created in the spaces for their benefit especially in accessing services and comfortability within the community, and this was much prevalent in the study that was conducted by Ross and Chekero (2018), where participants emphasized heavily on the importance of creating relations with the South African citizens. Participants mentioned these relations with the South African citizens were essential for their survival and adjusting to the country. Participants also mentioned that they felt safer, and they would know of any developing events that may affect their stay within the community, for example:

> *"What I like about my people at church is that they know I do not have papers, so if there is a roadblock somewhere or the police are doing rounds here in Tshikota, they just phone me to remain inside the house. Furthermore, that for me is like they like me and still want me to stay. I also share with them the challenges that made me leave home, and they are very supportive" ($P_4$)*

The study also found that these relations are needed for migrant's survival and coping within South Africa. These sentiments can be best shared with the findings of Ross and Chekero (2018), and Mafuwa (2015) who found that participants would adopt the South African culture which includes the language and dress code to ensure that they blend well within the community. These tactics employed by migrants are essential in erasing any identifiers of being a migrant and be instead accepted within the community.

### 4.1.2 Traditional Healers

Some of the participants mentioned that based on their beliefs, certain illnesses do not require the hospital. In such cases, they would consult traditional healers. It is much visible from the participant's responses that for them, illness does not only mean physical pain but other issues that do not require doctors. One of the participants mentioned that cultural factors play a role in getting ill such as *vadzimu* (ancestors). More so, the study that was conducted by Ross and Chekero (2018) discovered that many migrants are reliant on traditional medicines and private doctors as an alternative to public health care services.

*"So, in my culture, there are certain sicknesses that do not require the hospital. So if I have a serious problem like my stuff not going well or having a certain headache, it is best that you either see a Nyanga (traditional healer) or madzibaba (pastor)to get mushonga wako (get your medicines)" ($P_4$)*

### 4.1.3 Private hospitals

The participants also indicated that they would instead make use of private hospitals than public hospitals. They mentioned that as much as they pay for the service, they feel as though the attention and quality care received from the private hospital is worth the money they pay. Participants also mentioned that a thorough check-up is mostly done in a private hospital compared to an overcrowded public hospital.

*"Hay honestly I would rather go to a private hospital. I mean it is expensive, but that would be better than having to go through the public hospitals like you do not understand those people do not care"($P_1$)*

Furthermore, participants mentioned that within the private hospital mostly, they would provide an interpreter or allow the patient to bring someone who would be able to interpret the instructions given by the doctor:

*"You see with the private hospital at least they would use the language that I understand better, and I can ask some follow-up questions that I might have with regards to the medication that I am being given. The doctors from the private hospitals are very patient, maybe its because we pay money to be attended" ($P_5$)*

The study found that participants would mostly rely on private health care, over the counter medication, church and their social links with ordinary South Africans instead of relying solely on the public health care hospitals. These findings are in line with findings of the study that was conducted by Ross and Chekero (2018) and Mafuwa (2015) where participants mentioned that to gain their power and dignity, they have opted to make use of some of the services as mentioned above. Ahluwalia (2016) findings are also in line with the findings of the study, as it mentioned that the neighbourhood pharmacies play a significant role in servicing migrants, as they are usually disrespected within the public health care services based on their physical appearance and migrant status. Participants from the study also mentioned that they feel as though their citizenship is not much of an issue when they visit these services and are more welcomed. One can argue that, as

much as migrants revert to other alternatives for taking care of their well-being, they are exercising their resistance towards the socially constructed power among nurses. This is also a way of patients claiming their dignity and freedom of choice outside the public health care services. It further discussed the recommendations that would ease the experiences of the Zimbabwean migrant women experiences within the public health care services.

### 4.1.4 Bribery with the hospital staff and nurses

While other participants mentioned that they would rely mostly on the private hospital, some mentioned that creating relationships with the nurses is very important in accessing the medication without going through the trauma of physically going to the public health care service. One participant mentioned that if they are not well, they would ‘consult’ with their nurse friend, who would suggest the type of medication they should take, this would be done in the form of paying the of writing a prescription. The medication would be brought to them the following day, in a situation where the nurse is not in current possession of the medication.

> *"you know for me, and it has been much better causing the lady whom I work for is a nurse, so I just tell her that I am not feeling well and all that. She would then give me the medication or bring it the following day. So I do not need to go to the hospital unless it is something severe. This is the same lady who helps other families from home, they just consult, and then you just know that tomorrow you will get your medication, without going to the hospital. But its something we know we cannot just tell anyone cause she may be fired if other people find out" ($P_5$)*

This was one of the significant issues raised by the health personnel participants, who indicated that most of the health personnel staff are very corrupt and are tainting the hospital name negatively. Most health personnel have opted for extra income which includes corruption. As a result, patients suffer, as there will be high shortages of medication, which is dispensed for personal gain. Perhaps, the lack of resources that the public hospitals are faced to is mainly a result of corruption that is taking place within the health care services. These were also the remarks made by one of the health care personnel during the interview, that one of the significant challenges that they are experiencing as a hospital is theft of medication by the health personnel. Such findings, to a certain extent, deduce that the migrants are not responsible for 'depleting' resources, but instead, public health care facilities need to resolve the issues of corruption internally. Ross and Chekero (2018) study findings, where one of the participants disclosed that they had created

relations with the nurse who works within the hospitals to make it easier to access the health care services. The participant mentioned that:

*"I have a friend… who is a nurse at Giyani Health Centre? We stay together in the same house. We know each other from the Conquerors Ministry. When I get ill, or my child gets ill, I just send her [a] text message explaining the symptoms. After she knocks off, she comes back with the medication. That is how I am surviving. Through my friendship with [her], many Zimbabwean women I know are benefiting from her services. But she tells us not to tell anyone about it, as she risks being dismissed" (Ross and Chekero 2018 participant)*

These kinds of acts by the health care personnel uncover many rooted challenges that the public health care staff are faced with, as such they have resorted to other alternatives for their survival, although it is illegal. This then becomes a call for the South African government to evaluate internally the ways to overcome such acts which seem to compromise the needs of the patients.

### 4.1.5 Pharmacies (over the counter medication)

Other participants mentioned that usually, they would instead make use of the pharmacies rather than public hospitals. One participant mentioned that it is easier to buy medication rather than having to go through trauma in a public hospital for light medication such as paracetamol.

*"Ever since that experience trust me, I only go to the hospital when things are horrible but if I have things like flu I just go to the pharmacy, I mean it is better I pay for the medication rather than to be treated like a nobody in that hospital, people there do not care about you" ($P_4$)*

However, most patients mentioned the issue of pharmacies in passing, and this was mainly because to purchase the specific medication they would need a prescription, meaning they need to consult with the health personnel. This, therefore, acted as a barrier and participants were reluctant to utilize it more often. Similarly, to the studies conducted by Ross and Chekero (2018) and Mafuwa (2015) participants mentioned that they would mostly prefer to make use of the pharmacies as they gain their dignity. However, they usually use the pharmacy for necessary medications which does not require any prescription letter. Therefore, the pharmacy has become a place to purchase medication for short illnesses.

## 4.2 Conclusion

This chapter has discussed the alternatives that migrant women have adopted in tackling their experiences within the public health care services. It further discussed the recommendations that would improve the experiences of the Zimbabwean migrant women experiences within the public health care services. Based on the findings and discussions, the South African government has a huge role to play in ensuring that health care services are provided with enough resources and staff training. This is to improve the migrants' experiences.

Furthermore, the general public needs to be educated about the benefits of migration, rather than the current existing stereotypes of black migrants competing for resources with South African. It can be concluded from the above findings that interpreters play a considerable role in explaining the usage and intake of the medication to patients, and it is also a way to strengthen the relationship between the patient and the health personnel. Arguably, the lack of interpreters also acts as a contributor to the time that patients get to spend in the public health care services.

Due to the challenges that migrants are faced with in accessing public health care services, participants within the study mentioned that they have since relied on other services outside the public health care. More so, authors such as Ledoux et al. (2018) have come out arguing that overcoming the inequalities within the health care services means improving access, the quality and appropriateness of health services for immigrants. To honour, such views the study has forwarded some recommendations (which will be discussed in Chapter 5) which would assist in improving migrant's access to public health care services, these include intensive training of the health care personnel.

# CHAPTER FIVE

## OVERALL STUDY CONCLUSIONS, STRENGTHS AND RECOMMENDATIONS

### 5.0 Overall debates

This study has highlighted Zimbabwean migrant women's experiences when accessing public health care services in Makhado (Louis Trichardt clinic and Louis Trichardt Memorial Hospital). The challenges that were raised by the participants concerning the public health care seemed to affect migrants, whether documented or undocumented; however, the undocumented migrants are the most affected. What was majorly highlighted in the study was that, although migrants experienced challenges accessing public health care services, most of them mentioned that they would instead go through the humiliation and have access to the medication rather than going back to the Zimbabwean public health care services which do not have essential medication for patients.

Based on the study findings and the literature, the South African Department of Health should recognize and acknowledge the crisis within the public health care services, as indicated in Rispel (2012) who has densely argued that health care personnel are faced with enormous challenges within the working environment. The crisis and challenges which stem from the shortage of resources and ill-treatment of patients, discrimination harms the experiences of migrants who make use of the services. These findings are similar to the arguments made by Haskins et al. (2014) where health personnel indicated that the pressures that they are faced within the working environment result in many nurses releasing their frustrations on patients. The data collected has proved that the two public health care centres have failed the migrant women patients' dismally, by failing to uphold their policies, visions and goals. The Zimbabwean women migrant participants who took part in the study indicated that they have found it difficult to manoeuvre around the public health care services due to the discrimination they experience, which as a result strips their dignity. These conclusions are similar to those of Ojwang et al. (2010), who indicated that the negative attitudes of the health care personnel had violated the patients' constitutional rights through verbal abuse and discrimination. More so, the South African government should further realize the challenges that the hospitals are facing are not caused by migrants, rather, migrants become the bearers of the frustration that the nurses must go through daily. This stems from the

shortage of resources until such challenges are attended to, the public health care will continue to crumble. The study further concludes that South African citizens are also subjected to the maltreatment within the public health care system, as indicated in Crush and Tawodzera (2013) where they indicated that even South African citizens also are faced with similar maltreatment and discrimination within the public health care system.

The study findings resonate with the articles that have been written about the Louis Trichardt Memorial Hospital, which was labelled as the "The Hospital of Shame" due to the ill-treatment of patients. One of the hospital principles states that "*Una pfanelo ya uri musi a tshi ilafhiwa zwithu zwawe zwisi divhiwe nga vhangwe vhathu*" (Every patient has the right to keep their illness privately that they are being treated for privately", however, participants objected to this point. The participants mentioned that usually once health personnel or front desk staff member realizes that they are a foreigner, they would call them out using the illness of the patient in the view of other patients. Based on these sentiments, the hospital should have regular workshops to educate the health personnel and front desk staff on the importance of patients' rights to privacy and to practice compassion towards patients.

More so, the study can fully conclude that the two hospitals in Makhado (Louis Trichardt clinic and Louis Trichardt Memorial Hospital) have failed to uphold their mandate on the issues of language. The study findings show that the health personnel and the front desk staff have failed migrants in terms of the language. Participants mentioned that the issue of language was the main challenge that bares them from accessing public health care services. These conclusions are in line with those of Ross and Chekero (2018), where participants mentioned that they fear to access public health care facilities due to language challenges. This is regardless of the information provided at the Louis Trichardt clinic, which states that "Full explanation of how to take treatment will be given in patient's language". Instead, patients mentioned that they are mostly left to read the instructions on their own as the health personnel makes use of Tshivenda to communicate with them, which they do not understand. Through these lenses, the health care services are in dire need of interpreters to improve the experience of migrant women within the health care services.

The theory of Foucault (1980) on power and knowledge, played a huge role in understanding the power dynamics between patients and health personnel relations. The theory was useful in

explaining the power that health personnel have on using their home language, Tshivenda, to maintain social order within the public health care facilities. The same power was used by health care personnel to determine who can access the services within the public health care system, which mainly disadvantaged migrant patients.

More so, the study concludes that the two public health care facilities practices contrast with what is on paper, this goes back to the title of Ross and Chekero's (2018) study "On paper and having papers". The practices of the hospitals can be deemed as violating what has been laid out within the South African Constitution of 1996 which states "everyone has the right to access public health care, including reproductive health" and the National Health Act of 2003, which states that health care professionals may not deny a person emergency medical care. The participants expressed that health care personnel in the two public health care centres were discriminative towards migrant patients. As much as South Africa is considered to be one of the progressive countries towards health care services and protection of migrant rights, the study concludes that, regardless of the claims, migrant women are subjected to inhuman experiences within the public health care facilities, as they find themselves excluded from accessing the services based on the kind of documentation they possess.

Additionally, the study found the two public health care centres are faced with high levels of corruption, as indicated in Eyewitness News (EWS) published February 2019, where the CEO was suspended due to claims of corruption. The migrant participants indicated that they would instead bribe the health care personnel to access medication rather than being physically at the hospital. In dealing with migrants and the challenges that the hospital is faced with, participants put out some suggestions which might yield positive results on the image of the two hospitals. The participant mentioned that the overburdening of the hospital by migrants has led to many South African citizens suffering the consequences of not having access to medication.

## 5.1 Recommendations

Based on interviews, participants indicated that the following recommendations to the challenges that they are faced with in the public health care could improve:

### 5.1.1 Introduction of interpreters

The health personnel participants mentioned that communication with most migrant patients seem to be a challenge than they have imagined. It emerged that health personnel find it difficult to communicate and understand the illness that some migrant patients have, as they struggle to use English or any other local language to communicate. It has also been a challenge to explain how to take the medication to migrant patients. Therefore, to overcome the challenge, participants have suggested that the hospital should stick to its mandate as they have put up in the poster, to provide more interpreters to ensure smooth consultation with migrant patients.

*"We struggle to understand each other with the patients, and you realize as a nurse that you do not know their language. You get to spend so much time trying to explain or get an idea of what they are suffering from. If the hospital could provide us with more interpreters who should be on standby always, then our work will be made easier." (Focus group)*

These sentiments were shared by both the health personnel and migrant patients. It then shows it is a challenge that is faced by both parties and to tackle the challenge both parties feel as though the increase of the number of interpreters will improve the experiences of the migrants.

### 5.1.2 Staff incentives and intensive training and hiring of more nurses

The health personnel participants also mentioned that the work within the hospital was taking its toll on them. This is because of the lack of staff turnover, and they are required to work for long hours. Therefore, they suggested that the Department of Health should look deeply into hiring and training more nurses and doctors. This would make the work much manageable.

*"As I said to you earlier on that the most challenge we are facing is the shortage of staff and too much absenteeism, I think our department should look into increasing the capacity of the staff. Cause I think most of the staff become absent due to the intensity of the work, they have to endure at work. You are not so motivated to come to work cause the end will drain you of your shift. It is not an easy job dealing with patients" (focus group)*

One of the participants also mentioned that they feel most nurses need thorough education on how to interact with patients, as they need to be compassionate towards patients. The participants believe that the nurses should be educated on the policies and the challenges that they are faced with. They think this will translate into patients being treated with compassion:

*"I think the best thing will be training most of these nurses cause I do not think they deeply know how they should treat people and most of them are just ignorant" ($P_1$)*

### 5.1.3 Better working environment for the health personnel

The participants further mentioned that their work environment is not conducive for the kind of results they are expected to produce.. Having a lack of resources is one of the major setbacks towards their productivity in the workspace. Due to a lack of resources, it appears the nurses and doctors become blamed by the patients. With one of the participants mentioning that:

*"I love what I do, but there is no way that one can be productive as expected when you prescribe certain medication and you realize that it is not on stock or when you want to test patients' blood pressure and realize the machine is not working. Mind you it will take forever for that machine to be fixed. This is what most patients do not understand, they just think we are lazy people, but the conditions that we have to work under are making our work very difficult" (Focus group)*

Therefore, putting in measures to resolve the challenges that the nurses are faced with, will mean improved and better production, which as a result will improve patient's experiences within the public health care system.

### 5.1.4 Increased budget from the government for public health care services

Since both the hospital and the clinic seem to be easily accessible to many migrants, especially those who are from low-class background. It would be then advisable for the government increases its budget for each public hospital to cater for both migrant patients and local citizens.

*"You see, I feel like the government should increase the budget for hospitals. I feel like we will have fewer negative experiences, I mean resources will be enough for everyone since there will be enough staff for each shift and resources, then we will all be treated the same way" ($P_1$)*

It is more visible that the government should revise their budget yearly and ensure that they invest more in the public health care facilities, which seem to be playing a huge role for both migrants and local citizens.

### 5.1.5 Independent centres

To improve the migrant's access within the public health care system, hospitals should work hand in hand with independent centres where migrants can report their experiences anonymously to avoid victimization. These centres will also be able to deal with the challenge of corruption, and community members or citizens would be able to report any wrongdoings that are taking place within the health care system. This will lead to reduced rates of corruption and mismanagement of funds within the public health care system.

### 5.1.6 Increase of Mobile Clinics

The use of mobile clinics around the Makhado community could also help in reducing the overcrowding within the public hospital services. Not only that, but migrants can easily access these services. One of the migrant participants mentioned that:

*"There was a time when there was this other truck which was deployed in our community; people there did not care about the documents and all that. We went to test for HIV for free. If they can out such things in place, then it will be easy cause you will not spend so much time seating in the line waiting to see a doctor" ($P_4$)*

### 5.1.7 Media

One of the health care personnel participants mentioned that media played a negative role in portraying the Louis Trichardt hospital image, especially on exposing the matters that were taking place in such as that of Ms Magadalene. However, on the other hand, Maynard mentioned:

*"regardless of the negativity, sometimes the media covers the real things that are happening in the public health care fraternity, for example, the issue of medication theft." (Focus group)*

Most Zimbabwean migrant participants mentioned that the media plays a huge role in exposing the injustices that the hospital gets involved in. Furthermore, the media can act as an educational tool on erasing the negative perceptions and stereotypes that most South African citizens and health personnel hold towards migrants.

### 5.2 Significance of the Study

Although there have been several studies conducted on migration within the South African and African continent, not much has been done or known about the immigrant women's experiences in small towns such as Makhado, Limpopo. Importantly, authors such as Maringira (2011) have indicated that there is a considerable gap within the migration discourse, in the sense that experiences of migrant women are mostly ignored or spoken about in the general discourse of migration. This is mainly because the experiences of migrant women are often lumped with those of men resulting in continuous marginalization of women within the migration discourse. Precisely so, this study is significant in bringing to the fore Zimbabwean migrant women experiences in accessing the public health care services in Makhado, Limpopo, which is well known as a developing community. This is to ensure that all the public health care services are bidding by the South African Constitution in providing quality health care for all who live in South Africa. Most of the research studies around the topic of health services in South Africa focus on three metropolises of Cape Town, Durban and Johannesburg.

By focusing on the experiences of Zimbabwean women in accessing public health services in Makhado, this study highlights the experiences of migrant women accessing healthcare services in areas outside of the big metropolises. Given that there is little research that focuses on migrant women in deprived communities, the study aimed at bringing to the fore the struggles of immigrant women in South Africa. The study also adds value in bringing about some measures which are suggested by the participants to eliminate the existing barriers for migrant women in accessing healthcare services within the South African context. More so, the study is a starting point towards the decolonization of the migration concept, through focusing on vulnerable women who reside within small and underdeveloped communities.

Furthermore, the issue of healthcare access is paramount, especially taking into consideration the hardships that the migrants are faced with in their journeys to South Africa. Therefore, denial of

access to public health care “constitutes a violation of the internationally recognized right to access health care services” (Willie, 2018: 1). Furthermore, in the researcher's academic field where the discourse of development is of importance, as a scholar the researcher felt these issues are more pertinent in her field, and therefore we need to research more on, to bring about empowerment to women regardless of their nationality. As South Africans, we cannot claim that we are developing yet the 'other' group is not taken into consideration. Therefore, this study forms part of the development discourse. Not only that, but authors such as Makandwa (2014) have indicated that more research should be carried out in order to have a well-informed understanding of various challenges that Zimbabwean migrant women/mothers encounter within the South African public health care system. To honour such sentiments, this study has uncovered some of the experiences that Zimbabwean migrant women encounter within the public health care facilities in Makhado.

### 5.3 Research study Short Falls

The research was only limited to two hospitals in Makhado, and the number of participants makes it difficult to generalize the experiences to all Zimbabwean migrant women in South Africa. Furthermore, the research solely focused on the qualitative method, only if the research study adopted the mixed methods (qualitative and quantitative) the results would have been more reliable than using one methodology. Quantitative research methodology would have reached far many more participants compared to the face to face interviews. The data was collected using English as the medium of Communication with Shona speaking participants, most of the participants struggled in expressing themselves in English, which is a significant shortfall of the research, some information may have been omitted. One major challenge was that many migrant patients withdrew from the study, as xenophobic attacks and raids were taking place within the community. Thus, many participants feared that they might be exposing themselves, which may result in many being deported.

## 5.4 Research Study strengths

The study has successfully contributed to the understanding migrant's experiences in accessing public health care services in Makhado. To some extent, it has managed to uncover the challenges that Zimbabwean migrant women are faced with in accessing public health care services. More so, the study has managed to be the voice of the migrant women who have used the hospitals in bringing to the fore the kind of treatment that migrant patients are faced with. Understanding these

challenges means being a step closer to fully advocating more in improving the experiences of migrants within their host countries.

## 5.5 Possible Future research focuses on similar studies

Future studies can explore how unaccompanied migrant minors experience public health care services in South Africa. Other parts that are worthy of being researched are around the role and impact that the Non-Governmental Organization have in ensuring that undocumented migrants are granted access to public health care services in South Africa. Some further studies could be comparing different migrant groups in different locations. Since the study focused solely on Zimbabwean women migrants, a future study can focus on comparing South African women with migrant women in the same hospital, as the study did not focus on non-migrants.

## 5.6 Overall Conclusions

The study aimed to understand the Zimbabwean migrant experiences in accessing the public health care services in Makhado. The study discovered that migrants are discriminated against in public health care services through them is not a South African citizen, language and negative health personnel attitudes towards migrant patients. Due to these challenges, migrants have had to look for other alternatives in accessing health care, and these include the use of private hospital, churches, traditional healers, to name a few. Considering all the challenges, migrants have expressed that they would still prefer remaining in South Africa based on the opportunities that it has. They further mentioned that some ordinary South Africans had played an enormous role in their life to adjust to South African life.

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## APPENDIX A

**Research Information and Consent Form**

**M.Phil. Development Studies**

**Research project name: Understanding migrant women access to health services in Makhado, Limpopo**

**Participant Information Sheet**

I would like to invite you to take part in the above-named study but before you decide, please read the following information.

**What is the purpose of this study?**

This study aims to understand Zimbabwean migrant women access to public health care services in Makhado, Limpopo. Its focus is on the clinic and the hospital, understanding the services that are provided in ensuring that all migrants have quality access and positive experiences within the services.

**Who is doing the study?**

The study is being conducted by Takalani Yolanda Tshililo. I am a second-year M.Phil. In Development Studies candidate at the University of Cape Town. I was born in Limpopo and raised in Cape Town and did my undergraduate and Honors degree at the University of Cape Town. This study is being supervised by Dr Faisal Garba. This research project is in fulfilment of the for a Masters graduation.

**Who is being asked to participate?**

The study aims to interview five to eight black migrant Zimbabwean women who are residing in Makhado Limpopo and who also have used either the Louis Trichardt Memorial Hospital or the clinic. It also aims to interview participants who are not able to afford medical health insurance. The study will also interview three nurses (two from the hospital and one from the clinic). This is to understand the services that are available for migrant women in the hospitals especially those who do not understand the local language (Tshivenda). The study also looks to interview one paramedic to understand the services that are available for migrant patients who they must attend to within the communities.

**Your rights as a research participant**

Participation in this study is completely **voluntary** and **anonymous**. Information gathered during the research will be used solely for the purpose of this study and all efforts will be made to ensure the **confidentiality** of participants' personal information. Please note that while your name will be recorded with the data, it will not be used in the report. All identifiable data will be stored securely on a computer with password-restricted access and only the researcher (and supervisor if applicable), and ethics committee members will have access to it. All identifiable information will be destroyed at the end of the study or after the research project results have been released, whichever comes first.

If you decide not to participate there will not be any negative consequences. Please be aware that if you decide to participate, you may withdraw from the study at any time and your data will be returned to you or destroyed. You may also decide not to answer any specific question.

Informed Consent Sheet

Thank you for your participation. By submitting this form, you are indicating that you have read the description of the study, are over the age of 18 and that you agree to the terms as described in the short questionnaire that follows:

I have read this form and received a copy of it. I understand the purpose and nature of this study, and I am participating voluntarily. I understand that I can withdraw from the study at any time, without any penalty or consequences.

**I have had all my questions answered to my satisfaction**.

Yes
No

**I agree to take part in this study** and I hereby grant permission for the data generated from this research to be used in the researcher's publications on this topic.

Yes
No

I grant permission under the following conditions:

**I grant permission for the research to be recorded and saved** for the purpose of review by the researcher, supervisor / principal investigator, and ethics committee.

Yes
No

I grant permission for the research recordings to be used in presentations or documentation of this study.

Yes

No

**Participant's names and signature ______**

______________________________Date____________________

**Researcher's name and signature_**

______________________________Date

Contact

If you have any questions at any time about this study or the procedures, you may contact the researcher Takalani Yolanda Tshililo on 0848327954 or takalanitshililo@gmail.com t tshtak016@myuct.ac.za

# APPENDIX B

## Researchers Information Sheet

My name is Takalani Yolanda Tshililo. I am 23 years old and reading for my Master’s in development studies at the University of Cape Town. I completed my Bachelor of Social Sciences degree at the University of Cape Town in 2016. In 2017, I completed my Honors degree in Development Studies at the University of Cape Town.

For part of my Master's graduation, I am required to undertake a research project which is being supervised by Dr Faisal Garba from the University of Cape Town. Therefore, my research topic is Understanding Zimbabwean Migrant women access to public health care services in Makhado, Limpopo. For this study, I am required to interview participants are from Zimbabwe and those who work either in Louis Trichardt Memorial Hospital and Louis Trichardt Clinic. This is a qualitative study which involves in-depth interviews with the participants. Each participant is to complete a consent form (information shared will remain confidential, the identity of the participants will only be known to me) and to be handed the researcher’s information sheet.

Thank you for showing interest in my study.

Do not hesitate to contact me for any clarification.

## APPENDIX C

Semi-structured Interview questions with Zimbabwean migrant Women participants

## BACKGROUND INFORMATION

Age

Education background

When did you come to South Africa? Why did you come to South Africa?

How did you adjust in South Africa?

What immigration status do you use when you are in South Africa (permit, undocumented?)

What is your source of income in Makhado?

Have you ever fallen sick in South Africa that you went to a clinic or hospital seeking medical services?

How many times have you visited a hospital/ clinic?

Have you ever been asked for domination when you went to the hospital?

Were you asked for any proof of residence so that you can be attended to at any clinic or hospital?

Were you asked for any cash payment at any clinic or hospital? If so, how much

Were you able to make the payment that the clinic / Hospital which asked for cash?

What was the maximum time period you waited before you were attended by a doctor or nurse?

How was your hospital or clinic experience in general?

Would you ever recommend anyone from Zimbabwe to use the public clinic or hospital and why?

Are you aware of South African policy on health care for immigrants and refugees?

Do you think all the frontline staff at South African clinics and hospitals is aware of the policy and law on health care for immigrants?

How do you think the policies are applied by the frontline staff and nurses/doctors?

How was the attitude of the clinic/hospital frontline staff towards you the last time?

How was the nurses/ doctor’s attitude towards you on your last visit?

Have you ever had any language communication problems with both frontline and or medical staff at any clinic / hospital (Which language was used to communicate with you)?

Are there any alternatives that one can use instead of the public clinic/hospital?

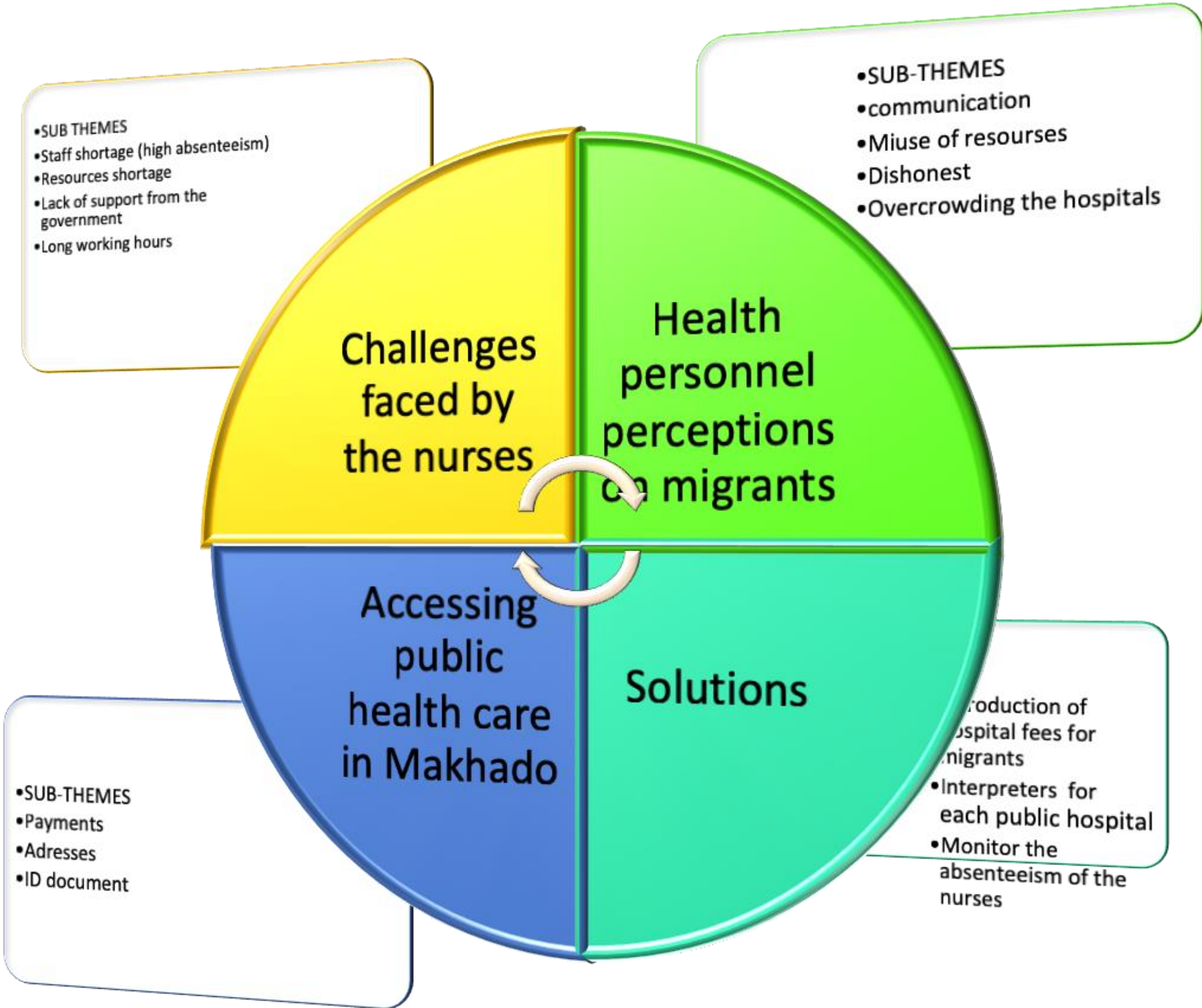
Have you ever been a victim of any foul language or xenophobia, name-callings such as 'kwere-kwere' at any clinic or hospital? If so, how did you feel about that?

Are South African citizens accommodative to migrants in general?

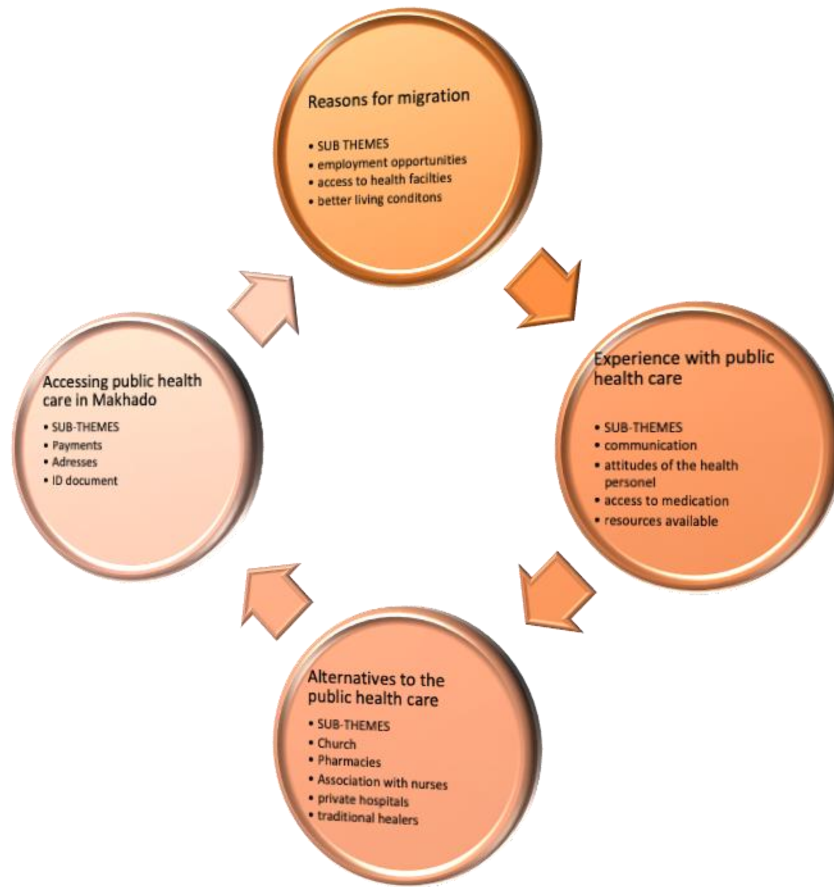
How would rate the efforts put by the South African government to help immigrants and refugees in accessing public health care and other social services

What do you think should be done to improve migrants’ access to public health care servic

**APPENDIX D: Summary of the Zimbabwean migrant's findings**



## Appendix E: Summary of Health Personnel findings



**Appendix F Field Work Extract**

28/12/2018

Field Work (interview with the first manager)

On this day I went to the hospital to talk to the CEO to allow me to conduct the interviews. Upon arrival I was directed to the Risk and Safety Manager who took me through the process and experiences with migrants and hospital challenges. He explained about a scenario which he was part of Zimbabwean lady who was involved in an accident being assisted by the nurses and the lady was asked on how she was feeling and she confidently responded on the well treatment that she has been receiving so far. The manager also mentioned that they do not take the issue of documentation into note. Such as when one is involved in an accident they get admitted immediately without being burdened with the lack of documentation. This he mentioned that it is not the problem, but the problem with migrants they tend to misuse the resources. Such as a person will fake being sick and get medication. He mentioned that most of the medication is then sold just after the Zimbabwean border post. However its not only migrants who misuse the resources but the staff as well as they steal medication and you realise that the hospital runs out of medicines for patients