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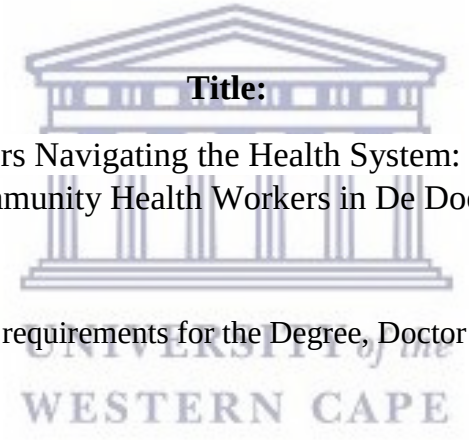
Faculty of Community and Health Sciences

DOCTORAL DISSERTATION



Title:

Agricultural Migrant Workers Navigating the Health System: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

Submitted in fulfillment of the requirements for the Degree, Doctor of Philosophy (PhD)

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KEY TERMS

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Migration

Primary health care

Public health systems

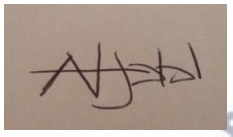
Seasonal agricultural workers

South Africa

Xenophobia

DECLARATION

I declare that this work, *Agricultural Migrant Workers Navigating the Health System: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape,* is my own work. I declare that this work has not been submitted for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.



Nafeesa Jalal

November 30, 2017

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DEDICATION

I dedicate this PhD to my parents, my Ammu and Abbu. Having grown up in Bangladesh, a country where education for girls continues to be a challenge because many do not believe in its importance, you have always worked tirelessly to provide your daughters with the best educational opportunities across the world. I am here today only because of your sacrifices and your constant encouragement.

KEY WORDS: ABBREVIATIONS AND ACRONYMS

AIDS - Acquired Immune Deficiency Syndrome

CHW - Community Health Worker

DOH - Department Of Health

EMS - Emergency Medical Services

HIV - Human Immunodeficiency Virus

ICESCR - International Covenant on Economic, Social and Cultural Rights

IOM - International Organization for Migration

MDG - Millennium Development Goal

MSF - Médecins Sans Frontières, also known as Doctors Without Borders

NDOH - National Department Of Health

NGO - Non-Governmental Organization

NHI - National Health Insurance

PHC - Primary Health Care

PI - Principal Investigator

PRISMA - Preferred Reporting Items for Systematic Reviews and Meta-Analyses

RA - Research Assistant

SA - South Africa

SADC - Southern African Development Community

TB -Tuberculosis

UHC - Universal Health Coverage

UNHCR - United Nations High Commission for Refugees

UWC - University of the Western Cape

WHO - World Health Organization

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ABSTRACT

Introduction:

South Africa has an estimated two million documented and undocumented immigrants. In addition, Statistics South Africa (2014) notes very significant internal migration. This mobile population is affected by chronic communicable and non-communicable diseases such as TB, HIV, and diabetes, although it has a Constitutional right to health and healthcare. Their quality of healthcare and disease control also affects the general population and the burden on the health system can be increased by inadequately managed chronic conditions as well as acute health care needs. Access to healthcare and continuity of care reflect both patient agency and the health system. Community Health Workers (CHWs) play an important role in linking communities and patients to health services and vice versa. The aim of this study was to understand how agricultural migrants in the Cape Winelands District of Western Cape Province of South Africa navigated the healthcare system to access healthcare services including securing continuity of care, and in particular the role of CHWs in this process, in order to inform policy and practice.

Methods:

This qualitative study in De Doorns, Cape Winelands District, used multiple methods including individual interviews, focus group discussions and care trajectory interviews, with a purposive sample of agricultural migrants, CHWs, facility staff and managers, and non-participant observation through accompanying CHWs while they work. Thematic analysis was the core analytic method, complemented by constructing care trajectories and descriptive statistics.

Findings:

The main barriers to access for De Doorn's migrant population identified in this study are: 1) an inadequately functioning appointment system; 2) importance of legal documents in accessing care, despite Constitutional and regulatory guarantees of a right to care; 3) language barriers; 4)

lack of patient confidentiality and respect; 5) long waiting times; 6) staffing and clinic resource limitations; 7) cost-based service denial; 8) missing patient files and misdiagnoses; and 9) clinic location and hours. Along with these, three pervasive cross-cutting issues with both direct and indirect impact on access were identified: 10) discrimination and xenophobic attitudes; 11) high levels of violence in the community; and 12) poverty and precarious livelihoods. The findings have also shown that despite all the challenges listed above, migrants value health, are exercising agency, and do their best to access services. The district has implemented a referral letter system to support continuity of care, but this paper-based system and other attempts at facilitating access fall short of the needs and of policy directives. CHWs actively contribute to access but some are constrained by requirements to check legal documents and by workloads and working conditions. Few migrant respondents had interacted with CHWs but they expressed support for the idea.

Conclusions:

The key determinants of access, continuity, and the lived experiences of healthcare lie outside of the health system and of "health seeking behavior", including discrimination based on nationality and lack of ID documents, pervasive violence, poverty, and precarious employment, while the determination and agency of migrants to survive and be healthy were positive determinants of access. Three overall conclusions can be drawn from this research. First, the details of access (or non-access) in a specific context matter, and these specific barriers and facilitators must each be addressed. Second, these distinctive factors or "details", some of which are specific to the De Doorns context, but many of which have been reported in other contexts in South Africa and around the world, cannot be understood or addressed separately from each other and from determinants of health outside the control of migrants, health workers, or the health sector. Third, migrants face barriers both similar to and distinct from those faced by the local population.

CHAPTER 1: INTRODUCTION

1.0 INTRODUCTION

Migration is a process of social change where an individual or group, for reasons of economic betterment, political upheaval, education, or other purposes, leaves one geographical area for prolonged stay in another (Bhugra, 2004; Matzopoulos, 2009). Reasons for migrating vary and are often broken down into basic categories: forced (due to war, political persecution or environmental catastrophe) or voluntary (such as for economic betterment), internal or international (cross-border), and regular or irregular (with or without legal documentation such as visas and work permits) (Freemantle, 2015).

South Africa has an estimated two million documented and undocumented cross-border migrants, which amounts to about 4% of the total population (Batambuze, 2015). In addition, Statistics South Africa (2014) notes significant internal migration: from 2011-2016, the Western Cape and Gauteng experienced an estimated inflow of approximately 344, 830 and 1, 106, 375 internal migrants respectively (Statistics South Africa, 2014). Access to healthcare for this large population is an important issue.

When apartheid ended in 1994, the large majority of the population, who had previously been excluded from most healthcare, now had to be served by a poorly-prepared health system. While the public health system has since been shaped into an integrated and comprehensive national service, it has still not managed to serve everyone who needs it (Coovadia, 2009). Failures are still found in political leadership and weak management, which have led to inadequate

implementation of what are otherwise good policies. Important aspects of primary healthcare are still not in place, and there continues to be a notable human resources crisis which the health sector has to cope with (Ibid). The HIV epidemic, with SA being home to the highest number of people living with HIV in any country, has added to and accelerated health sector challenges (Ibid).

This thesis therefore explores how agricultural migrants in the Cape Winelands District of the Western Cape Province of South Africa navigate and experience the healthcare system in South Africa, including the roles of community health workers (CHWs) in enabling access and maintaining continuity of care. According to the International Organization for Migration (IOM), and for the purposes of this study, the term *migrant* refers to "any person who is moving or has moved across an international border or within a country away from their habitual place of residence, regardless of their legal status, whether their decision to move was voluntary or involuntary, the cause for the movement, and the length of stay" (IOM, 2017).

Both internal and international migrants will be considered in this study. For the former, the movement occurs within the border of the same country; in the latter, migration involves movement across the borders of two or more countries (IOM, 2004; UNESCO, 2011). Theoretically, maximizing the benefits and minimizing negative effects for migrants of the migration process, regular or irregular, should be achievable. However, in practice both regular and irregular migrants face challenges arising from the allocation of resources and health services (IOM, 2004; UNESCO, 2011).

The health of mobile populations has an impact on the broader population of a country. Like sedentary populations, mobile populations are affected by chronic communicable and non-communicable diseases such as TB, HIV, and diabetes, and have a right to health and health care (Coffee, 2007; Lurie & Williams, 2014). Therefore, the quality of health care and disease control that mobile populations receive also affects the general population, and the burden placed on the health system can be worsened by inadequately managed chronic conditions and acute health care needs (Lurie & Williams, 2014).

Migrants are often healthier than non-migrant populations when they newly arrive in their host countries, and this is known as the 'healthy migrant effect' (Malmusi *et al*., 2010). They often have better health statuses (and may also be better educated) when leaving home, as compared to the population of those who stay back; this is known as the positive selection of migrants (Ibid). Some migrant groups, however, face challenges to their health, although the mobility of people is not in itself automatically risky (Zimmerman *et al*., 2011). These health challenges are often seen to be associated with the living and working conditions in their new homes, which include unfavorable, unsafe, and overcrowded living spaces, poor food security, limited employment opportunities, and violence (or the fear of violence) related to their migrant status, such as xenophobia (IOM, 2010). These health challenges are then amplified by migrants being socially excluded, and facing socioeconomic hardships resulting from xenophobia and other barriers to accessing health and social services (Ibid). Research has shown that healthy migrants contribute to the economic betterment and socioeconomic development of both their countries of origin and host countries (Landau & Kabwe-Segatti, 2010). However, these benefits of migration and health

are often overlooked, especially in the context of a resource-constrained health system that has often not provided migrants with the services they need (Vearey, 2012).

1.1 HEALTH SYSTEMS AS A DETERMINANT OF MIGRANT HEALTH

An important role of the healthcare system is to improve public health. Demographic changes across populations have been ongoing worldwide, and this trend is anticipated to continue over the next decade (Betancourt *et al*., 2003). This magnifies the importance of addressing disparities in health and access to the health care system (Ibid), as it impacts the health of both the local and migrant populations.

Access to healthcare for migrants is influenced by a number of factors. Key issues include legislation and policy related to migration and migrants, as well as their implementation, the roles and functioning of health systems including CHWs, rural poverty, and internal vs. international migration.

For the purpose of this study, *health system* will refer to the public, biomedical health system. To the knowledge of the primary researcher, there are no private facilities in De Doorns. People did not refer to traditional medicine, so this was not explicitly included.

By law, every person living in South Africa, regardless of their country of origin or legal status in the country, is entitled to equal access to primary health services, as outlined by the National Department of Health (NDOH, 2007). The Department of Health has clarified that primary health care, including ARVs and TB medications, is an entitlement of all residents of South

Africa, with or without documentation (Ibid). Documents such as identity cards, international passports, or valid visas are not formally required for migrants in South Africa to access health services (Vawda, 2014). In practice, however, this right to access to primary health services remains far from being fully realized in South Africa (Ibid).

Despite policies which support migrant rights to health care in South Africa (NDOH, 2007), migrants have limited access to public services such as health, sanitation, banking, and education (Coffee, 2007). Access to healthcare and continuity of care are a function not only of constitutional or legal "rights", but also, perhaps especially, of both the patient and his/her social networks, and the health system. In the context of the health system, providers should provide adequate healthcare services - and policies, mechanisms and resources are needed to enable this "supply" to happen (O'Donnell, 2007). However, patients, including migrants need to seek the appropriate healthcare. Thus, resources such as information, financial means, and social support are needed to enable this "demand" to be effectively expressed (Ibid).

CHWs are one such resource available to migrants, as they can provide information and support in the navigation of health services. An important role of CHWs is to link communities and patients to health services and vice versa (Witmer *et al*., 1995). However, the role of CHWs in facilitating access to health care for mobile and migrant patients and communities has received little attention. A recent study in KwaZulu-Natal (Uwimana, 2015) has highlighted the lack of structural mechanisms to follow – or even identify – patients who do not stay at their initial or primary site of care, and the limitations on actions by CHWs or other health workers in helping to ensure continuity of care across district, provincial or district boundaries.

Migrants make up a substantial portion of the patient population in communities such as De Doorns, the site of the research reported in this thesis. With its high rate of internal and international migrants, and a high burden of communicable and non-communicable disease, there is an urgent need to understand how migrant populations navigate the health system, and how the health system and CHWs in the area respond to their needs. Rural poverty facing the community as a whole, including migrants, exacerbates inadequate access to services and quality of care. Initial access to care and continuity of care reflect the interactions of decisions and actions taken by patients, their social networks, and health care providers, in a context of the health system and its policies and structures, as well as the broader social, economic and political context (Mazars *et al*., 2013).

Health sector policies and practices do not take sufficient account of the needs of patients who are mobile – whether or not they are considered "migrants" – both for their own health care and as a public health issue (Kruger, 2015; Uwimana, 2015). Studies such as that of Collinson (2010) have shown that some migrants are at high risk of sexually transmitted infection including HIV (Collinson, 2010). Together with limited access to services, this increases the risk of inadequately managed health conditions, including contracting and transmitting infections such as TB and HIV (Mazars *et al*., 2013). Universal health care policies must therefore be clearly defined, designed, implemented and sequenced (Vawda, 2014), as well as monitored and evaluated for effectiveness. Various players within the health system in South Africa, including the public sector, private sector, NGOs, and local and foreign donors to health projects, need to achieve clarity in these policies.

South Africa is one of the countries in the world which have established a constitutional right to health and health care for all, including both documented and undocumented migrants (Ngwena, 2000). The South African experience is of interest both because it explores what actually happens within a country that specifies this right and also because it can contribute to broader public debate and policy development around the right to health for all populations.

1.2 BUILDING ON EXISTING RESEARCH

For years, thousands of South Africans and other Africans have migrated to agricultural areas of the Western Cape each year to work on the farms. In recent times, many farmers require a skilled yet much smaller permanent labour force than they historically required (Barrientos & Visser, 2012). However, there remains a need for temporary (often seasonal) unskilled labor, resulting in a rapid influx of workers from rural areas in other parts of the country and cross-border to small agricultural towns in the province (Atkinson, 2014). Areas with highly intensive horticultural crops are often the ones with small farms located near towns, where it is feasible to transport labourers to and from the residential areas in which they live. The Western Cape's agricultural sector is a typical case of this (Ibid).

Research conducted by James Kruger, this area's Deputy District Manager until 2016, for his MPH (Kruger, 2015) was among the first occasions where the Western Cape's district health departments directly tried to learn about and plan for migrants. Kruger's thesis noted that there is willingness by government to adjust policies and practices surrounding healthcare services for the study site populations (Ibid).

This study builds on the recommendations made by Kruger that in-depth qualitative research be conducted to further comprehend the needs of the people living in these settlements. While Kruger's research found that a large majority of migrant agricultural workers and their families had used the local public-sector clinic at least once for a variety of health conditions, this finding of greater-than-expected utilization was accompanied by reports of serious concerns by the study participants (Kruger, 2015).The current study explores how migrants navigate and experience health services to secure both initial access and continuity of care, and it is the first exploration of the roles CHWs play in relation to the health needs of migrants in this area.

The findings and recommendations of this Doctoral research may inform policy and practice development, serving the migrant population in both the Western Cape and other parts of the country. In addition, analysis of the experiences of migrants and the health system in this part of South Africa may contribute to current global debates and public policy developments on mass migration.

1.3 PROBLEM STATEMENT, AIMS AND OBJECTIVES

Problem Statement: South Africa (SA) has the largest numbers of migrants entering its borders of the Southern African Development Community (SADC) countries, at an estimated two million documented and undocumented cross-border migrants, which amounts to about 4% of the total population (Batambuze, 2015). Aside from this being a region with significant levels of migration, it also has a high communicable disease burden and continues to struggle with its public healthcare systems (Vearey, 2014). While there is a policy of free primary healthcare for all, as outlined in the South African Constitution as well as the National Health Act, its

interpretation and implementation are less inclusive in practice. As a result, migrants face challenges with accessing health care, and existing healthcare responses have not engaged adequately with migration (Walls *et al*., 2015).

Research on migration and health is a growing field in South Africa and the Southern Africa region. However, there are still significant knowledge gaps, such as understanding if, how and when migrants receive care, whether that care is sufficient or not, what their experiences with the health system are and what facilitators and deterrents in accessing initial care and continuity of care migrants experience. In order to contribute to filling some of these gaps, this study explores how agricultural migrant workers in the Cape Winelands District of the Western Cape Province navigate and experience access to health care in De Doorns, and ongoing access across jurisdictions to maintain continuity of care, and the roles of the CHWs as possible facilitators of access to services.

Aim: The aim of this study is to document and understand how agricultural migrants in the Cape Winelands District of Western Cape Province of South Africa navigate the healthcare system of South Africa, with respect to accessing healthcare services including securing continuity of care. It is also to explore the roles of CHWs in this process, in order to inform policy and practice.

Objectives:

1. To document existing health sector policies/mechanisms to support access to and continuity of care for mobile populations in South Africa, in relation to international good practice.

2. To explore and analyze how agricultural rural migrants in the Cape Winelands District access healthcare services;

2a) to document care trajectories through which agricultural migrant workers have accessed or not accessed health services in De Doorns; and

2b) to explore facilitators and barriers to access as perceived by agricultural migrant workers, community health workers, facility staff, and managers.

3. To explore how agricultural rural migrants in Cape Winelands District secure ongoing access/continuity of care across jurisdictions over time;

3a) to document care trajectories through which agricultural migrant workers have secured ongoing access/continuity of care in De Doorns; and

3 b) to explore facilitators and barriers to ongoing access/continuity of care, as perceived by agricultural migrant workers, community health workers, facility staff, and managers.

4. To explore the roles that CHWs play in facilitating access to healthcare services by agricultural migrant workers within the district, and continuity of care across jurisdictions, as perceived by CHWs, agricultural migrant workers, health facility staff, and health sector managers.

1.4 OUTLINE OF THE THESIS

The thesis begins with this brief introduction to the key issues addressed by the research reported here: migration; access to health care and continuity of care; the intersection between health systems, social determinants of health, and individual and community experiences in shaping

access and the experience of care; and the roles of CHWs in facilitating access to health care by migrants in this agricultural area. Chapter 2 introduces the conceptual framework which guided the research and presents the design and methodology of the study, as well as the study setting. Chapters 3 and 4 review international and South African literature on access to care by migrants, and Chapter 4 presents key legislation and regulations shaping access to care by migrants – especially cross-border migrants – in South Africa. Chapter 4 thus also addresses Objective 1 of the study. Chapters 5 to 7 present the major findings of the research. Chapter 5 discusses distinct yet interconnected health systems factors affecting access to care, from the perspective of migrants as well as health workers and managers. Chapter 6 focuses on challenges and strategies related to maintaining ongoing access to, or continuity of, care. It addresses health sector and individual patient strategies, but focuses particularly on how migrants experience two key social-structural determinants in relation to health, access and continuity of care: violence and poverty. Chapter 7 presents findings related to the roles of CHWs in relation to migrant health and access to care, from the perspectives of both CHWs and migrants. Chapter 8 discusses the overall findings of the research in relation to the research questions and existing literature. It also presents a personal reflection on the process of undertaking this study, and suggests recommendations for policy, practice and future research.

CHAPTER 2: CONCEPTUAL FRAMEWORK, METHODOLOGY AND ETHICAL CONSIDERATIONS

2.1 STUDY DESIGN

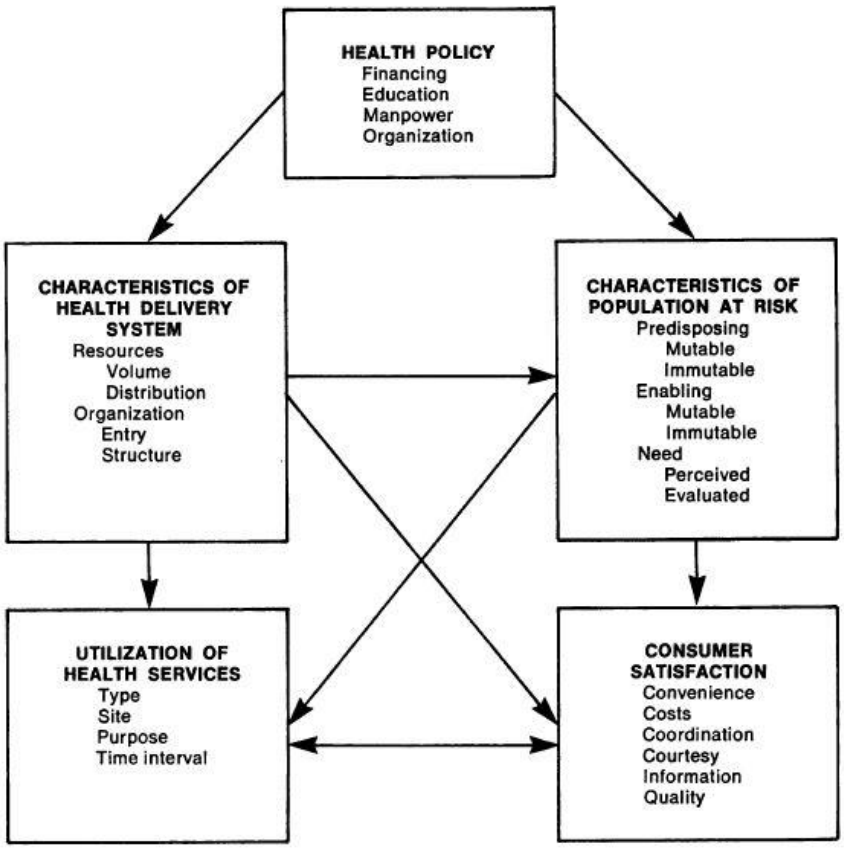
This research employed an exploratory qualitative study design using multiple methods including document review, individual interviews, focus group discussions, and non-participant observation through accompanying CHWs while they work. Qualitative research uses a pragmatic approach that seeks to understand experiences in context-specific settings, such as "real world settings where the researcher does not attempt to manipulate the phenomenon of interest" (Patton, 2014:39). The design is appropriate in this study because it is best suited to describing participants' (notably migrants' and CHWs') perceptions and the meanings they attach to their experiences. The choice of a qualitative design was also in response to the

recommendations of a senior district manager who, on completing a large community survey, strongly recommended that qualitative research be undertaken to go more deeply into the contextual and experiential aspects of agricultural migrant workers' and their families' access to and utilization of health services (Kruger, 2015). As Kruger's quantitative study introduced many issues of concern in relation to migrants and their access to health services in De Doorns, the primary researcher strongly recommended a qualitative study to examine them in depth. The study design and research process will be discussed in detail after the following section on the conceptual framework.

2. 2 CONCEPTUAL FRAMEWORK

This study's theoretical framework was guided by Aday and Andersen's Framework for the Study of Access (Figure 2.1 below). As the primary aim of this study was to learn how migrants access and navigate their way through the rural South African health system, this framework provided a comprehensive understanding of the various facets of access and potential barriers to that access. This framework guided the research process, including the study design, instrument development and data collection. The study used both inductive and deductive reasoning. Inductive reasoning was used as themes emerged from the data, influencing the development of the analysis and intrepetation. The framework supported the deductive component of the data analysis, as it was used to organize and present the themes which emerged through the data categorization process.

Figure 2.1 Aday and Andersen's Framework for the Study of Access to Medical Care (1974)



Source: Aday and Andersen, 1974, p. 212. This framework has been replicated with written permission from the publisher.

In order to preserve and/or improve health, it is important to facilitate access to the usage of relevant health care resources for populations (Gulliford *et al*., 2002). Individuals impacted by the health system, policy makers, implementers, and those who are on the receiving end of services are concerned about access to health services (Aday & Andersen, 1974). Access is a complex concept (*Gulliford et al*., 2002). In this study, the research focuses on experiences of access and utilization (care trajectories), but in a broader health system, policy, and social context. While the researcher also consulted other frameworks because aspects of them were

relevant, such as the WHO's analytical framework for selecting appropriate interventions in low-income Asian countries (Jacobs *et al*., 2012), Aday & Andersen's framework was chosen because it was developed to bring together multiple dimensions of access and context, integrating or synthesizing or building on other frameworks that focus on one or a few elements. Along with this, the researcher chose this framework because it allowed for the development of a comprehensive picture and analysis of the many interacting factors influencing access, continuity, and experience of care among these agricultural migrants.

Although the geographic aspect of access is commonly discussed, especially for rural settings where facilities are fewer, there is also the socio-organizational aspect to consider. The sex of the medical care provider, whether they charge a fee, or if they have a relevant specialization are all important to consider, and are included in this framework. Beyond this, the 'willingness to seek care' is also an important aspect of access that should not be ignored (Aday & Andersen, 1974).

An individual's decision to seek healthcare depends on many factors, including social and cultural definitions of the conditions they are suffering from. If there is a stigma around a health condition they are suffering from, they may not want to visit a health facility. Hence, when tackling issues of access and eliminating barriers in order to provide a genuinely accessible health care system in South Africa, Aday and Andersen's framework (1974) provides a comprehensive and systematic way of approaching many interacting aspects. Migrants comprise a large, growing, prominent, and diverse group within South African society, and they are often underserved by public services (Hnilicová & Dobiášová, 2012). Their health impacts not only their own well-being but also the well-being of the communities and economies in which they

live and to which they contribute (Ibid). Migrant health therefore demands attention from policy makers and health professionals.

The components of the framework addressing the objectives of the study were reflected in the structure of the sample, the structure of the interview guides, and the probes. Data collection proceeded with understanding of the relevant health policy context, developed via a scoping review and a literature review. The scoping review and literature review addressed the first objective of the study by documenting existing health sector policies/mechanisms supporting access to and continuity of care for mobile populations in South Africa, in relation to international good practice.

Several of the elements in the framework helped to analyse and understand the context. *Consumer satisfaction*, which includes cost of care, quality, and convenience all guided in understanding the context in which care is being provided. *Health policy*, which includes financing, manpower, and organization of services all also helped to understand the context in which care is being received. For example, short staffed clinics which are not large and/or organized enough, or competing policy objectives manifest through contradictory documents such as the Constitution on the one hand, and Department of Health directives on the other – these elements are discussed in subsequent chapters. The gap that this thesis has found between policy and practice suggests that health policy may in fact not always be a significant determinant of access. It nevertheless remains important in situating this study, as the existence of policies is necessary for their potential implementation.

The next element is *utilization of health services*, which also includes the type of services provided, assisted in understanding under what context migrants felt motivated to use services. The element *population at risk* in the framework was reflected in the selection of study site, the focus on the perspectives of migrants, and building on and interpreting findings in relation to earlier research. Utilization of health services was linked to consumer satisfaction, which impacts access to health care and continuity of care, addressing the second and third objectives. The interview guides were structured to provide numerous opportunities to express satisfaction and dissatisfaction, as well as suggestions for improvement. Lastly, the health delivery system highlighted the key roles of the CHWs and other healthcare resources, satisfying the last objective and linking to the scoping and desk review at the outset. Thus, the Aday and Andersen (1974) framework aligned intimately with the objectives of this study. Figure 2.2 below, *Objectives and Data Collected to Achieve the Objective*, lists each objective of this study, what data collection method was used and which group of participants were involved.

Figure 2.2 Objectives and Data Collected to Achieve the Objective

OBJECTIVES	DATA COLLECTION METHOD	PARTICIPANTS INVOLVED
Objective 1: • To document existing health sector policies/mechanisms to support access to and continuity of care for mobile populations in South Africa, in relation to international good practice	• Scoping Review	
Objective 2: • Explore and analyze how agricultural rural migrants in the Cape Winelands District access healthcare services • Document care trajectories through which agricultural migrant workers have accessed or not accessed health services in De Doorns • Explore facilitators and barriers to access as perceived by agricultural migrant workers, community health workers, facility staff, and managers	• Individual interviews • Focus groups	• Migrants • CHWs • Health Facility Staff • Health Sector Managers
Objective 3: • Explore how agricultural rural migrants in Cape Winelands District secure ongoing access/continuity of care across jurisdictions over time • Document care trajectories through which agricultural migrant workers have	• Individual interview • Care trajectory interviews	• Migrants • CHWs • Health Facility Staff • Health Sector Managers

secured ongoing access/continuity of care in De Doorns • Explore facilitators and barriers to ongoing access/continuity of care as perceived by agricultural migrant workers, community health workers, facility staff, and managers		
Objective 4: • Explore the roles that CHWs play in facilitating access to healthcare services by agricultural migrant workers within the district and continuity of care across jurisdictions, as perceived by CHWs, agricultural migrant workers, health facility staff and health sector managers.	• Individual interviews • Focus groups • Non-participant observations	• Migrants • CHWs • Health Facility Staff • Health Sector Managers
TOTAL NUMBERS	• Individual interviews (migrants, CHWs, staff and managers combined) n= **53** • FGDs (migrants and CHWs combined) n= **31**; total participants n= **84**) • Non-participant observations with CHWs n = **3** • Additionalcare trajectory interviews n= **6**	• Migrants n= 56 • Community health workers n= 12 • Clinic staff n=3 • District and Provincial Manager n=2

2.3 OVERVIEW OF STUDY METHODOLOGY

This study unfolded in two phases, with some overlap between phases through iterative sampling:

Phase 1: Documentation of South African health sector policies and mechanisms to address access and continuity of care for mobile populations (desk literature review), which was complemented by a scoping review of the international literature on access and continuity of care for mobile populations.

To satisfy Objective 1 of this protocol, the researcher undertook a scoping review in 2016 which commenced with the searching of international literature and any existing international guidelines (e.g. from WHO, IOM, MSF) on the issue of access to health and continuity of care for mobile populations in South Africa. Next was a search of South African references and grey literature for policies, guidelines, and examples at SADC, national DOH, provincial DOH, and NGO level. The researcher conducted another search in 2017, during the period of writing the final dissertation, to add new literature. The detailed search strategy, inclusion and exclusion criteria, and methods of analysis are explained and presented in a modified PRISMA flow diagram in Chapter 3, which was based in part on the scoping review.

Phase 2: The Scoping Review informed the second phase of empirical data collection. Empirical data collection focused on documenting and understanding the perspectives of migrants, community health workers, health facility staff and managers on access and continuity of care. All interviews, focus groups, care trajectories and participant observations were conducted during this phase.

The research sought health sector as well as community-based perspectives on access, continuity of care, and role of CHWs. Member-checking, a participant validation technique, explores the credibility of findings (Birt *et al*., 2016). Findings are shared with participants to confirm that their experiences were recorded accurately (Ibid). Through focus group discussions (FGDs), the research conducted member-checking and interpretation of findings with health sector and community stakeholders.

The study methods included individual in-depth interviews, FGDs, and non-participant observation. The individual interviews with migrants included a general care trajectory for access and for continuity; a detailed care trajectory of their most recent use of services and/or attempt at securing care; and a semi-structured interview exploring facilitators and barriers in general, including who helps them secure access, and the roles of CHWs. Individual interviews with health sector respondents also followed this guideline, from the perspective of the respondent. In addition to the care trajectories in the other interviews, six additional ones were done with selected migrants to understand the continuity of care process for migrants living with chronic conditions. The researcher developed FGD guidelines based on the preliminary analysis of the individual interviews, and used open-ended questions to allow respondents to suggest their own opinions and feelings on the issues. The exact tools and questionnaires used in the study have been included in Appendix 2.

Non-participant observation was conducted by accompanying CHWs during their regular work day. Three CHWs were observed for one day each, which allowed for 4 - 6 hours of interaction with and observation of CHWs on each day. It included observation of 3 - 11 interactions with

CHWs and their patients and other individuals, complementing the formal interviews and focus group discussions with CHWs, migrants, and health care providers and managers.

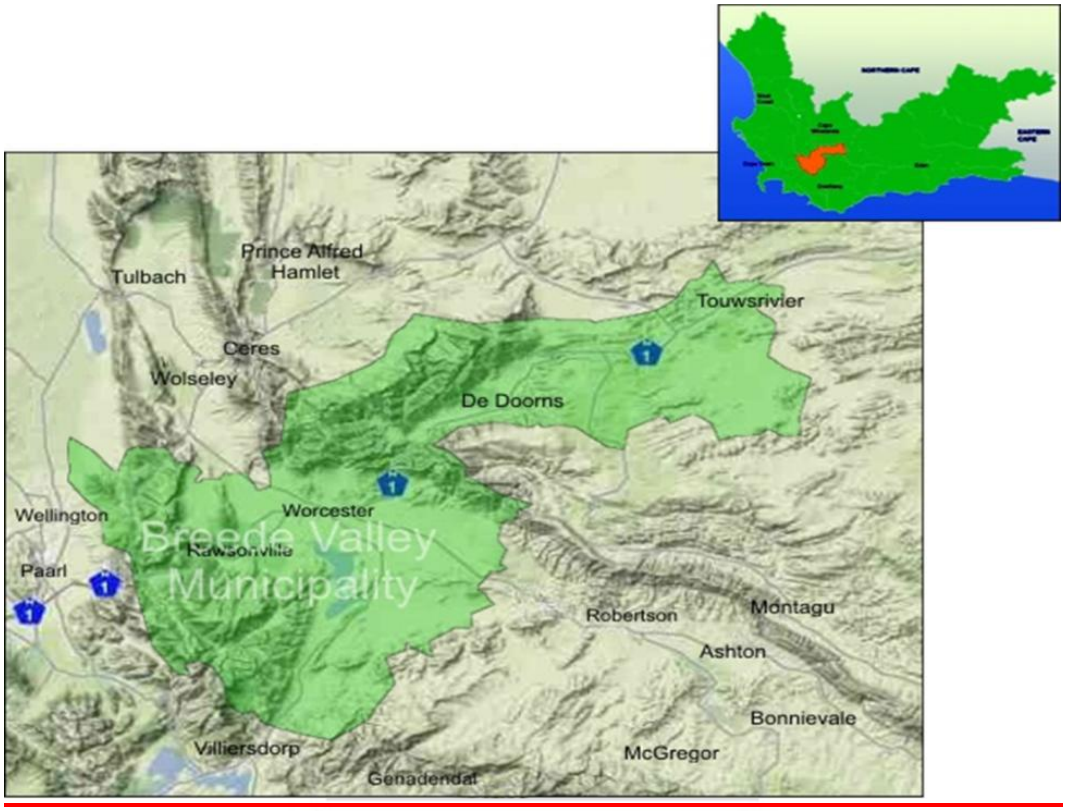
The thesis includes available demographic information for each quote that is shared in the major Findings (Chapters 5 - 7). Some participants shared less than others and at times the Research Assistant did not record demographic information.

2.4 STUDY SETTING AND SELECTION OF STUDY SITES

The study was conducted in the Cape Winelands District, in De Doorns town, and in the peripheral settlements of Lubisi and Stofland. De Doorns lies in the Brede Valley municipality in the Western Cape, roughly 27km north of Worcester and 152km north of Cape Town (PASSOP, 2010). Lubisi and Stofland are relatively newly developed areas on the periphery of the more established town of De Doorns (Kruger, 2015). They consist of both formal and informal housing. While most of the CHWs in this study lived in formal housing, most migrant participants lived in informal accommodation.

Figure 2.3: Map of De Doorns - Breede Valley Sub-district

Source: Kruger, James (2015)



This study was built on the recommendations of James Kruger's Master's thesis titled, "Community Perceptions of Comprehensive Primary Health Care and Crèche Services for an Agricultural Rural Migrant Community in De Doorns in the Western Cape" (Kruger, 2015). Kruger, a manager in the district health system, had recommended that in-depth qualitative research be conducted to further comprehend the needs of the people living in these settlements.

These two settlements are of scientific and public health importance because they include a large and diverse migrant population, yet there is only a single healthcare facility (the De Doorns clinic) to serve them. This makes it possible to limit the variability between facilities in understanding patient experience and overall barriers and facilitators. The De Doorns clinic is a

primary health care clinic, and there are no other health facilities serving the De Doorns population, public or private. The health facility is situated in the old part of the town. When the clinic is closed, the primary option is to call an ambulance, which arrives from and takes patients to the government-run Worcester hospital. Worcester is roughly 33.5km away. However, there are two other government clinics in the area, Sandhills clinic (12 km away) and Orchard clinic (five km away). These serve the farming communities nearest to them.

Agriculture is the base of the local economy, consisting primarily of the farming of table grapes on approximately 204 farms in the area. According to a community-based non-profit organisation in Cape Town, People Against Suffering, Oppression and Poverty (PASSOP), the wages for farm work in De Doorns are amongst the lowest in the country (PASSOP, 2010). Despite this, De Doorns has an abundant supply of trained, competent labour, due to large scale labour migration from neighbouring countries and other provinces. It is estimated that roughly 11,000 migrants come to the area in search of employment each year, primarily to work during the table grape season which is from February till May of each year; the official population of De Doorns is 10, 583 (Statistics South Africa, 2011; Theron, 2012). Theron's work reports that most of the foreign migrants in the De Doorns area are from Zimbabwe and Lesotho, with the latter arriving more recently to the area (Theron, 2012).

2.5 DATA COLLECTION METHODS, SAMPLING PROCEDURE AND SAMPLE SIZE BY RESPONDENT GROUP

The data collection period for this study was January to May of 2016. For this research, the migrant population included has been defined as those who have migrated to De Doorns (from

another part of South Africa or another country) for the purpose of agricultural employment. The migrant populations coming from many parts of South Africa have originated from rural communities and their primary reason for migration has been to seek employment, even if seasonal, in this part of the country (Collinson, 2010).

Although the primary focus of the research was to understand migrant health experiences in their own voices, facility staff/managers and CHWs are an essential part of the health system in rural areas, and their voice was important in understanding the overall health experience of migrants in the study areas. Hence, this study employed a purposive sampling strategy to include migrants, CHWs and facility staff/managers. The study was designed to learn about the health-seeking behavior and experiences of agricultural migrants in the Lubisi and Stofland communities.

a. Agricultural Migrants

Inclusion criteria for the study participants (migrants) were: any individual who is 18 years or over, lives in a household in either of the study areas, identifies themselves to be a migrant, and who has at some point in the *last 12 months* worked on the farms in the area, or was currently working on a farm.

The study included both people who reported satisfactory continuity of care and have successfully navigated through the health system, as well as those who have not had satisfactory experiences of access and continuity of care. The sample was designed to build on participants who have been involved in Kruger's recent survey (Kruger 2015), to allow for a richer qualitative

analysis. Six participants were recruited who reported a chronic condition requiring continuity of care, in order to be able to construct care trajectories based on the initial and follow-up interview. The migrants were adults of both genders, both new and long-standing migrants, and both South African and foreign migrants. For the purpose of this study, long-standing migrants are those who have lived in De Doorns for a year or longer. Those who had language barriers were also included. This sample included people who have reported using services, and those who have not. The focus was to cover the range of pertinent perspectives and then continue until saturation was reached.

b. Community Health Workers (CHWs)

Inclusion criteria for the CHWs were: any individual who is 18 years or over and served the population in Lubisi and/or Stofland within De Doorns. CHWs sampled consisted of both genders, served both study sites, and were employed by the DOH and an NGO; six CHWs were selected from each of these two employers. They included both experienced and new workers to allow for a better understanding of the skill sets being utilized. Individual interviews with CHWs, and non-participant observation through accompaniment of CHWs over a full work day, were completed for three CHWs. All CHWs were invited to participate in the FGDs. The groups consisted of both previously interviewed and non-interviewed CHWs.

Of the CHWs included in this study, only one was male, and he was also the only male CHW serving the community. All CHWs in De Doorns were employed by one of the two NGOs. One CHW included in the study was employed by both NGOs. Whether or not a CHW was specifically serving the migrant population was not a part of the inclusion criteria. In the event

that they were not, this was still important data to note and understand. Most CHWs in the study, however, did have migrants on their list of people to care for.

c. Clinic Staff

Inclusion criteria for clinic staff were: any individual who is 18 years or over and worked at the De Doorns clinic (as that is the only health facility serving this study's population). The sampling of staff/managers at the facility included both genders and consisted of senior and medium- to lower-ranked staff that have had interactions with the migrant populations. One male and two female health workers participated in the study. While specifically serving the migrant population (or not) was not a part of the inclusion criteria, all three of the participants did report that they were serving the migrant population directly in their work.

d. Health Sector Managers

Inclusion criteria for health sector managers were: any individual who is 18 years or over and worked in a managerial role at the District or Provincial level, influencing care either directly or indirectly for the migration population in De Doorns. Both males and females were in the inclusion criteria. One male (district-level manager with knowledge of community programs and CHWs) and one female (provincial-level manager) participated in the study. The participant from the provincial level was based at the Worcester hospital, which was heavily used by the migrants in De Doorns, and she was well-versed on issues surrounding access to care for migrants. While the participant from the District level did not have direct interaction with the migrant population in De Doorns, he was involved in the planning of services for that area and was able to comment on issues pertaining to the research questions.

e. Sample Size by Method

Twelve interviews of a homogenous group are sometimes all that is required to attain saturation in some qualitative studies (Guest *et al*., 2006). However, the number of interviews exceeded this minimum of twelve because of the diversity of perspectives sought, and for policy impact it is believed that the greater the number of interviews, the more defensible the study (Mason, 2010). Thus, recruitment of participants continued within the available time (3.5 months of fieldwork, as funding did not allow for a longer stay in South Africa), on an on-going basis.

The 3.5 months of concentrated PhD fieldwork coincided with the grape season in De Doorns, as the agricultural migrants worked on grape farms. It also built on a previous period of six months in South Africa in 2013, which included field visits to the study site, qualitative interviews with migrants in other parts of South Africa (Cape Town and rural KwaZulu-Natal), and participation in research and practice networks on migrant health. Every effort was made to carry out the study as planned. Except for a few interviews which were not possible for other (non-time related) reasons, including the feedback workshops with stakeholders that had been envisaged, all data collection listed below was successfully completed in this time frame:

- 37 individual in-depth interviews, three FGDs (with a total of 19 participants) and six additional care trajectory interviews with migrant participants.
- 11 individual in-depth interviews and two FGDs (with a total of 12 participants) with the CHWs, representing both the organizations which employed CHWs for De Doorns.
- Three in-depth interviews with clinic staff.
- Two in-depth interviews with district and provincial managers.

For some categories of respondents, such as the three CHWs involved in non-participant observation or with some categories of health care providers or managers, all available respondents were interviewed – either because no additional participants could be recruited, or because all individuals in this category were recruited. While it cannot be stated that saturation was reached for those categories with small numbers of participants, the research did not find significantly divergent perspectives within any category. Thus, the study reached saturation across the overall sample.

Of the five FGDs held in total, the composition of each (by gender, language spoken, nationality, and other variables) was informed by the earlier phases of the project, as the FGDs were purposively designed to gather deeper insights into issues raised during individual interviews.

This study therefore consisted of 64 data collection sessions, which included individual interviews, focus group discussions, non-participant and participant observation, and care trajectory interviews. The sample of participants included migrants, CHWs, clinic staff, and hospital management. Table 2.4 lists the gender, age, location of birth, and location of current residence for the participants. To note, the non-participant observation with CHWs is not listed in this figure, as they were not formally tape-recorded interviews, but rather based on notes taken by the researcher.

2.6 INSTRUMENTS AND PILOTING

The researcher developed the interview guides and all corresponding instruments through a multi-step process. First, an outline was made with initial thoughts on what kind of questions

needed to be asked in order to answer the study's research questions. Next, Kruger's quantitative instruments were reviewed, to gain an idea of what kind of questions were asked in his study. As this study was a qualitative extension and expansion of his work, it was useful to review what participants were previously asked. Thirdly, the researcher reviewed instruments used in a prior qualitative study from 2013 focused on documenting migrant lives. Based on the questions used in that study, and the other tools reviewed, the instruments for this study were created. A number of research colleagues at the University of the Western Cape, reviewed all questions used in this study, and this was done in collaboration with both supervisors for this study. Input received resulted in several revisions being made. For example, mid-way through the research process the researcher introduced a number of new questions to the interview guide, to encourage participants to elaborate on certain points. These questions were important as emerging themes came up which merited further exploration. The data from the new questions introduced was analyzed using iterative sampling strategies, where each stage of data analysis helps to determine subsequent means of data collection and analysis (Denzen, 1978; Palinkas *et al*., 2015). The interview guide and tools, in the various languages, have been included in Appendix 2.

Aday and Andersen's framework guided the instrument development, as it allowed for the thinking of various aspects of access, and impacted how and what was asked through the interviews and focus group discussions.

The researcher revised the interview questions based on the findings of the scoping review and literature review, and on the advice of researchers working on migrant health and with CHWs, and were piloted in De Doorns (De Vos, 1998). One in-depth migrant interview and one in-depth

CHW interview was conducted for the pilots. This allowed for the interview questions to be further revised. The final version, with necessary changes based on piloted feedback, was used for the actual study.

2.7 RECRUITMENT OF PARTICIPANTS

The initial recruitment plan was to be in close proximity to the De Doorns clinic daily, as it was a populated area with a high concentration of migrants. The first research assistant hired went into the clinic on several occasions to speak with those waiting, to secure them for an interview after their visit. However, this was not successful, as people were often tired and hungry after their long hours at the clinic and not interested in an interview. Others could not be found outside the clinic at the time they agreed to meet, or reached on their phones. Along with this, no interviews could be conducted during their waiting time (i.e. taken to a private place while keeping their place in the queue) because this was not possible at the De Doorns clinic. The clinic is short-staffed with large numbers of people waiting for services, and the level of organization and patient management was not able to accommodate it.

The next recruitment plan was for the researcher to drive and walk through the study areas with her research assistant(s) to find participants. The research assistants and CHWs assisted with recruitment by speaking to people in the communities about details of the study, to gauge interest. The assistance of CHWs was useful, as they are a part of the study and know the community hubs well. Individuals who participated in the Kruger (2015) study were also invited to participate when possible. Subsequent recruitment occurred through sequential referral sampling from a number of different sources who were asked for referrals to build a final,

diverse, purposive sample. While this was not formal Respondent Driven Sampling (Heckathorn, 1997), it diversified the starting points for eventual triangulation of the data. The questions asked and the responses heard (i.e. the issues that were expressed) were similar regardless of the process of recruitment used for the participants to arrive to this study.

The researcher obtained written consent from each participant, with all data collection methods used. The information sheet describing the study was translated into all major languages spoken by the participants: English, Xhosa, Sotho, and Afrikaans. Each participant read the information sheet, and was able to freely ask questions, before signing. The research assistant read to the participants who were illiterate, and the study was explained to them in detail before they signed and/or marked the consent sheet to confirm acceptance of being in the study. All participants were told verbally and in writing that they could stop the interview at anytime, for reasons they did not have to explain.

Based on previous qualitative research with documented and undocumented migrants in South Africa, and on the very high response rates in Kruger's study, no major difficulties in recruiting participants was anticipated. However, there were some difficulties in the recruitment process due to the fact that agricultural migrants are transported to work early in the morning, and only return between 4-6pm. After a full day of work, many were not enthusiastic to be interviewed. The research overcame this by interviewing participants who did not go to work on the day of the interview, either due to feeling ill or for other reasons. Some interviews were also conducted in the late evenings and on weekends. Undocumented migrants and those with stigmatized conditions such as HIV were equally responsive to invitations to participate in the study as other

migrants. Some participants were recruited later in the study after overall rapport and trust had been established in the community.

No incentives were offered in the recruitment (or any other) period. Modest refreshments (cold drinks, fresh baked goods, and fruits) were offered during FGDs, but these were not mentioned during the recruitment into the study.

One research assistant was hired and trained for the data collection, and was required to speak the local languages spoken in the community: isiXhosa, Sotho (for the migrants from Lesotho), English and/or Afrikaans. As the first research assistant resigned 1.5 months into the fieldwork, a second assistant (one of the CHWs who was a research participant and willing to work after hours) was hired and trained, with the same language requirements satisfied. She was hired only for support with the interviews, not transcriptions. While a possible limitation could have been that this CHW's role in the community may have impacted the responses of the participants (when she was in her RA capacity), the researcher planned a strategy to mitigate this in advance. While she was familiar with the hubs and assisted with areas where migrants resided, those she interviewed had never interacted with her previously.

Both assistants were trained to collect the data in a uniform manner, and assigned to areas based on their language competencies (Kruger, 2014). Data collected was transcribed, and where necessary translated into English before transcription after the fieldwork was complete. A graduate student from the University of the Western Cape, who had previous experience with

both processes and spoke all languages used by the study participants, carried out the translation and transcription. The primary researcher briefed and supervised the student.

2.8 DATA COLLECTION AND DATA MANAGEMENT

The study included migrants who were both employed (working on the farms) and unemployed (not currently working on the farms, but had previously worked on the farms). Hence, hours of data collection included both daytime hours and evenings, to be accommodating of their schedules. Each interview lasted 20 – 45 mins approximately, and each interview recording was given a unique number to anonymize the transcripts.

A research assistant was present for all sessions, for translation purposes when required, and note-taking purposes at all times. The most common countries of origin represented in the FGDs and this study overall were Zimbabwe and Lesotho. Within South Africa, migrants from the Eastern Cape were highly represented.

If participants were not comfortable being interviewed in English, interviews were done in local languages by two trained and supervised research assistants, with the principal researcher being present for all of them. All participant forms were translated into Afrikaans, Zulu (or Xhosa) and Sotho, to cover the main migrant populations in the study areas.

The study included care trajectories to complement the individual interviews. “Care trajectories” refers to a method used in medical anthropology (Kleinman, 1988). It is the rebuilding of detailed histories of an illness or care-seeking process, prospectively or retrospectively, then

using these to look for patterns of care-seeking, and to structure or triangulate identification of factors or associations. For example, one might find that "in all cases an exacerbation of symptoms immediately preceded action x", or "in most cases work trumps health", or that "no (or all, or some) respondents spontaneously identified people who helped them navigate access, but that all (or no, or some) respondents could name specific people on probing." The researcher invited respondents to tell the story of their condition and care-seeking through in-depth interviews, and that story then became a key data element for analysis (Murray *et al*., 2005).

Care trajectories may be used as the main instrument in a research project, or as a complementary method to strengthen rigor through method triangulation. This research used them as a complementary source, in addition to the instruments described, and as a specific component of in-depth interviews to complement direct questions about the factors of interest.

All interviews were translated (when not in English) by the individual who was hired for this study's translations and transcriptions. She was orientated by the study's primary researcher on the purpose, objective, methods, and other details of this study, so that she was familiar with the context of the study as she translated and transcribed the recordings. The accuracy of translations and quality of work was checked by the primary researcher by randomly selecting recordings (when in English) and comparing them with the transcripts. For the non-English recordings, the same steps were followed by this study's co-supervisor, who was familiar with the other languages used.

2.9 THE FINAL SAMPLE AND ITS IMPLICATIONS

Table 2.4 Demographic Details of Study Participants

Category of Participants	Gender of participants (Male/ Female)	Age of participants (Male/Female)	Location of Origin (Male/Female)	Location of Current Residence
MIGRANTS (Individual interviews, focus groups, and care trajectories) Total migrants = **56**	Total M = 9 (16.1%) Total F = 47 (84.0%)	Median of M = 30.5 Median of F = 31.0 (Note: FGD participants did not disclose age due to group set-up) Interquartile: M = 26.0 – 35.0 years of age Interquartile: F = 25.0 – 40.0 years of age	Zimbabwe M = 1 Zimbabwe F = 14 Lesotho M = 6 Lesotho F = 22 Mozambique M = 0 Mozambique F = 2 Eastern Cape (SA) M = 2 Eastern Cape(SA) F = 4 Free State (SA) M= 1 Free State (SA) F =1 Sterkspruit (SA) M =0 Sterkspruit (SA) F = 1	Lubisi M = 5 Lubisi F = 19 Stofland M = 4 Stofland F = 20 De Doorns (area unspecified) M = 0 De Doorns (area unspecified) F = 8

			Rustenburg (SA) M =1 Rustenburg (SA) F =0 Queenstown (SA) M =0 Queenstown (SA) F =1	
CHW (Individual interviews and focus groups) Total CHWs = **12**	Total M = 1 (8.3%) Total F = 11 (91.7%)	Median of M = 56.0 Median of F = 36.0 Interquartile M = 56.0 Interquartile F = 29.0 – 42.5	De Doorns and surrounding areas	Lubisi M =0 Lubisi F = 4 Stofland M =1 Stofland F =7
CLINIC STAFF (Individual interviews) Total clinic staff = **3**	Total M = 1 (33.3%) Total F = 2 (66.7%)	Undisclosed	South Africa	De Doorns (and surrounding areas)
HOSPITAL MANAGERS (Individual interviews) Total managers = **2**	Total M = 1 (50.0%) Total F = 1 (50.0%)	Undisclosed	South Africa	Western Cape

As presented above, only nine of the participants from the individual interviews were men, and only two of the focus group discussions included both males and females. The majority of

participants originated from Zimbabwe, Lesotho and the Eastern Cape. The participants ranged from 22 to 56 years of age, and all resided in De Doorns (in either Lubisi or Stofland) at the time of this study, as per study protocol.

2.10 DATA ANALYSIS

Once the data was translated and transcribed, the researcher read it in full, and then re-read it in full three more times, for content familiarity and to understand the overall story found within each transcript, before the manual coding process began. Each transcript was manually coded in extensive detail for content-related categories, using the data management software Atlas.ti. This software kept the categories organized, and generated a document listing all codes and all quotes related to each code. The researcher then organized the categories generated from these into themes related to the conceptual framework and research questions, and this also allowed for emergent themes from the data. The following references were found to be useful in helping to address the coding and analysis process:

a. Qualitative Coding & Analysis. Research Rundowns. Retrieved from https://researchrundowns.com/qual/qualitative-coding-analysis/

b. Saldana, J. (2009). The Coding Manual for Qualitative Researchers 2009; reprinted in 2010. Second edition in 2013. SAGE Publications. Retrieved from http://stevescollection.weebly.com/uploads/1/3/8/6/13866629/saldana_2009_the-coding-manual-for-qualitative-researchers.pdf

c. Patel, S. (2014). A Guide to Coding Qualitative Data. Retrieved from http://salmapatel.co.uk/academia/coding-qualitative-research

d. ATLAS.ti: Types of Coding. University Library, University of Illinois, Urbana-Champaign. Retrieved from http://guides.library.illinois.edu/atlasti

e. Richards, L. (2009). Handling Qualitative Data: A Practical Guide. SAGE Publications.

The researcher placed all codes under 24 established categories, which were collapsed into four main themes/headings. Those headings have been organized into three of the four Findings chapters of this dissertation. Atlas.ti software supported data management of the qualitative data. Preliminary analysis of the data was ongoing and iterative, having informed further recruitment, follow up interviews, and the interpretive FGDs.

2.11 RIGOR, VALIDITY AND RELIABILITY

Rigor ensures the quality of the research process, and can therefore translate into trustworthy findings (Saumure & Given, 2008). Rigor can be defined through maximal validity (ensuring that the study evaluates or measures what it intends to measure) and reliability (ensuring accuracy of measures) (Ibid). The terms reliability and validity are essential in a study, as are the terms credibility and confirmability; consistency, dependability, and applicability are also essential guidelines to adhere to for quality (Patton, 2014). Patton (2014), when discussing the researcher's ability and skill in any qualitative research, also states that reliability is a consequence of the validity of a study. In addition, qualitative researchers have stressed the need for some kind of qualifying check or measure for their research (Golafshani, 2003). For example, Creswell and Miller (2000) suggested that validity is affected by the researcher's perception of validity in the study and his/her choice of paradigm assumption. Reliability is determined by how reproducible the results of one study are to another study, conducted under different circumstances (Roberts *et al*., 2006). This study uses the terms rigor, encompassing reliability, and validity.

A number of mechanisms have maintained rigor in this study. Beginning with ethics, this study has offered transparency by clearly the defining aims, objectives, and research methods. Participants recruited have all been provided with an information document, in a language they understand, which has included all details of the study and their roles. Each participant has undergone an informed consent process. The purpose of the study was again explained before beginning the interviews, so that participants have had several opportunities to add ideas or ask questions which may be relevant to the aims but may not have been directly asked. In this, as in many qualitative studies, triangulation (using two or more methods in a study in order to check the results of one and the same subject) of data sources and questions has been a central aspect of ensuring rigor (Golafshani, 2003). Additional measures to enhance validity were member checking at the end of each interview, and the feedback and interpretation of FGDs.

Both research assistants were trained in the study protocol and interview administration to enhance comparability of interview methods and therefore of results. To check that the administration of the interviews was similar across interviewers ("reliability") and that qualitative interviews were probing adequately to make sure that the questions were well understood and answered ("validity"), the researcher reviewed a random sample of interviews for completeness and accuracy on a weekly basis. In addition, debriefing of interviewers helped to assess any challenges. Finally, the principal investigator was present for all interviews, focus groups, and observations, conducting all English ones herself and guiding the research assistant in those conducted in other languages.

The researcher constructed interview questions with input and suggested revisions from other researchers in the field, and piloted these in advance, so they were appropriate and relevant. Each interview was completed thoroughly and recorded on tape, with accurate documentation of each response. Each participant had a safe and comfortable space to express themselves, each response was kept confidential, and the participants were assigned an identification to keep them anonymous. Qualitative research can often not be replicated completely, as no two sets of results will be the same; that said, this study was designed in a comprehensive and transparent manner, so that the steps of this study and the rationale behind each step were clearly understood by all.

2.12 ETHICAL CONSIDERATIONS

2.12.1 Permission to Conduct the Study

Ethics approval was sought and obtained from the University of the Western Cape's (UWC) Senate Research Committee, as well as the Provincial Research Committee of the Department of Health, prior to the commencement of data collection. This study also abided by the guidelines described by the Medical Research Council, as the UWC School of Public Health recommends of all studies which involve human subjects. The ethical approval document has been included in Appendix 1.

2.12.2 Benefits and Disadvantages of the Study

Researchers were able to identify and explore challenges in the healthcare services through direct assistance from the participants. Thereafter, recommendations enabled them to improve/modify/add on services. There are limited publications surrounding this area of study;

therefore, this research has brought forth recommendations for possible changes in the health services for the population in the area. Hence, participants have indirectly benefitted through their participation by sharing their healthcare experiences. The participant accounts were documented, and recommendations have been included in several chapters of this dissertation, with the intention to develop scholarly publications as well as policy briefs and other practice-relevant communications.

There were no financial incentives for participants. However, light refreshments were provided to participants of the FDGs, as they lasted over one hour.

The primary researcher and research assistants were vigilant for unforeseen challenges and/or discomfort to participants, but based on earlier research including Kruger's (2015) study, they did not foresee significant harm/disadvantages for participants at any stage of this study. The study was transparent, confidentiality was a priority, and all tools consisted of carefully crafted questions which did not infringe on the participants' level of comfort or sense of security. Participation at all times was voluntary, and participants had the option to withdraw from the study at any stage, without any explanation. There were no foreseen risks to participants regarding their disclosure of migration status and/or health conditions. There were also no foreseen risks to any of the staff or managers who participated in the study.

2.12.3 Participants and Confidentiality in the Data Collection Process

As a primary researcher, there is a need to consider potential harm that could occur within the research study. This was prevented by structuring the research proposal and entire study

according to the ethics principles outlined by the Declaration of Helsinki, World Medical Association (2013), and by respecting the dignity and human rights of voluntary participants by explaining the research study before participation. The proposal was also guided by the University of the Western Cape ethics requirements. Participants signed a written informed consent form after being given sufficient time to ask questions, to ensure autonomy. They were assured of confidentiality and anonymity in reported findings.

Participation was always voluntary with individual, informed and signed consent. In cases where illiteracy was concerned, verbal, recorded consent was taken. Community consent is important, as is individual consent. Hence, every effort was made to introduce the study to key people in the community, as their input was valued. The research fully adhered to the protection of anonymity and confidentiality of respondents. Each participant was provided a copy of their signed consent and confidentiality documents, alongside details of the research in a language of their understanding.

The researcher obtained additional consent from participants who agreed to be photographed, as a potential photo journalistic exhibition may be included following the completion of the dissertation (the researcher is also a professional photographer). This exhibition would be accessible to the communities in which the study occurs, and other venues which may benefit from the results of this study. The researcher has requested and received permission to take and use photos and she was careful to exclude any photos that might cause discomfort, embarassment or risk to the people in the photos. The photos included in this thesis are from this study.

Feedback will also be provided to the various groups involved in the study, such as the participants, key policy and decision makers in the Western Cape health sector, community organizations, and others with a vested interest. Joint feedback sessions with James Kruger, whose Master's thesis this PhD elaborated on, will also be considered.

Some in-depth interviews took place at participants' homes if the participant was comfortable with speaking in detail while other members of the household were potentially around, while some took place in the primary researcher's car, and others at an outdoor location in either of the communities. The researcher observed no difference based on the location of the interview. At each setting, an RA accompanied the primary researcher to communicate in the local language of the participant, and it was prioritized that the participant was comfortable and clear on the setting, purpose and process of the interview.

The FGDGs took place at the office of one of the two NGOs providing CHWs to the De Doorns communities at the time of the study.

CHAPTER 3: LITERATURE REVIEW - POLICY AND PRACTICE FOR MIGRANT ACCESS TO CARE

3.0 INTRODUCTION

This chapter reviews literature regarding regional (African) and international health sector policies, guidelines and good practices related to access to health services for migrant populations and continuity of care for that population, including the roles of Community Health Workers (CHWs). The researcher used a scoping review methodology to identify and review relevant literature. This chapter is based on the scoping review and a subsequent update of the literature, in response to emerging themes in the research. Scoping reviews are conducted for numerous reasons, including identification of research gaps in the existing literature (Najafizada *et al*., 2015), and this is one of the underlying objectives of this literature review. The other

objective is to understand recent migration trends, and the global context of migrants and their access to healthcare. This will be done by identifying existing international policies and best practices, which may inform implementation within the South African context. While South African legislation will be presented in Chapter 4, some literature will also be discussed in this chapter.

Some of these issues have also been raised by other authors, and these additional references are cited where appropriate. While this chapter introduces relevant South African literature and policies, specific policies and regulations relevant to the study objectives are also documented in Chapter 4, and both chapters focus on Objective 1 of this study: To document existing health sector policies/mechanisms to support access to and continuity of care for mobile populations in South Africa, in relation to international good practice.

3.1 SCOPING REVIEW: POLICIES AND GOOD PRACTICES FOR MIGRANT ACCESS TO HEALTH CARE

This section begins with an explanation of the review process, followed by an introduction to the current migration context and issues pertaining to healthcare for migrants. This is followed by various regional and country experiences, including that of South Africa. This begins with Europe as a continent, sharing examples of various European countries, before moving to non-exhaustive examples from Kenya, China and Canada, and then a section specifically focused on South Africa. Next there is a review of recommendations from key organizations, conferences, and governing bodies, followed by a section documenting current challenges, discussion, and further recommendations. The final section is on CHWs, to understand their role in migrants

accessing care. While some recommendations will be shared in the conclusion section that follows, others will be provided throughout the chapter where the various issues are introduced.

a. Scoping Review Methods

The central question of the scoping review was, “What are the existing guidelines, policies and best practices on access to healthcare for migrants?"A sub-question was, "What role, if any, do Community Health Workers (CHWs) play in facilitating access to healthcare for migrants?" The search terms and sources were broad enough to capture different study designs (Najafizada *et al*., 2015). Both the central question and the sub-question will be discussed in this chapter.

To locate policies, guidelines and best practices for migrants' access to healthcare, the researcher conducted a search of electronic databases and gray literature from websites of relevant international initiatives in 2016. 571 articles were found using various sources (listed below), and imported into Zotero, a citation management software. Utilizing the pre-defined exclusion criteria, and screening for titles, abstracts and duplicates, each article was screened and either included or excluded. The inclusion and exclusion criteria are presented in Figure 3.1, and a modified PRISMA flow diagram of the search is presented in Figure 3.2. 274 of the articles were excluded and 298 articles were included after the screening was completed. The researcher read the abstracts of these 298 articles to identify which articles would be best suited for potential inclusion, and created a final inclusion list of 104 articles. Of the 104, 42 have been included for more in-depth review in this chapter as indicated in the introduction, as they contained content which was most relevant to this study’s focus as mapped against the defined research questions. Articles included were in English and dated from 2005 to 2015.The researcher updated the

literature review with a further search in 2017, and incorporated the updated content was throughout the chapter.

Websites of key organizations were important to include, as they gave a flavor of current (or changing) debates and perspectives. The strategy to identify websites to include in the scoping search followed 2 steps: first, the study listed organizations and government sites which were commonly cited in journal articles and mainstream media to include migration and migrant health-related content; and second, the websites were screened to be in English and include content published within 2005 – 2015.

The following websites were included in the scoping search:

- MSF – Doctors Without Borders (www.msf.org)
- IOM – International Organization for Migration (www.iom.int)
- WHO – World Health Organization (www.who.int)
- UNHCR – United Nations High Commission for Refugees (www.unhcr.org)
- SADC – South African Development Community (www.sadc.int)
- Western Cape government (www.westerncape.gov.za)
- South African Department of Health (www.health.gov.za)

The following databases were included in the search:

- Google Scholar
- Medline (Ovid)
- PubMed

- PAIS International
- Scopus
- Embase
- Cochrane Library
- Ovid Healthstar

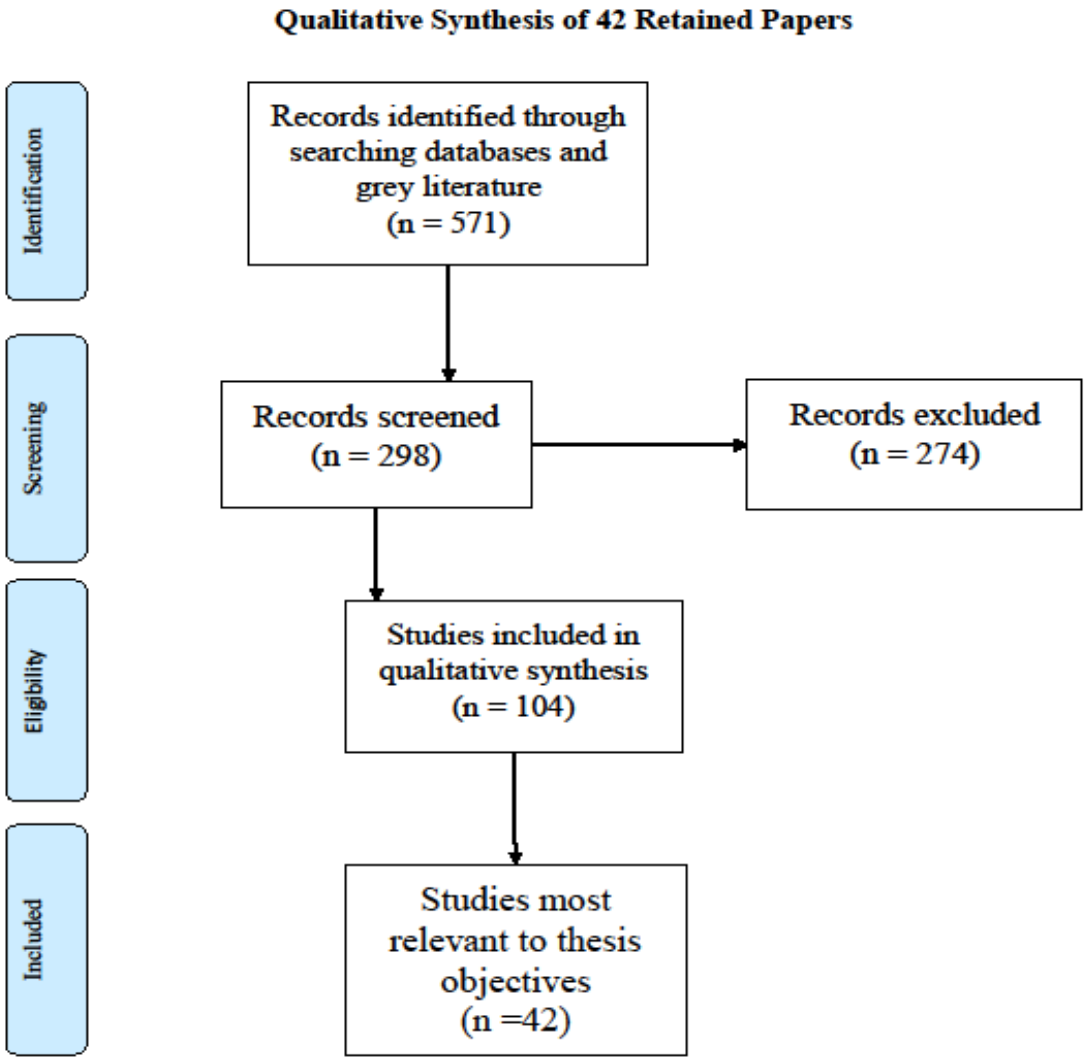
The project leader (NJ) and a research assistant searched for articles for possible inclusion in the review. They used two methods to search for papers: electronic database searching (i.e. PubMed, Medline, and Google Scholar) and manual reference list searching. Each database was searched using Medical Subject Headings (MeSH) search phrases which are listed in the Inclusion and Exclusion Criteria (Figure 1) below. The reference list of the papers identified through the database search was also searched.

Figure 3.1 Inclusion and Exclusion Criteria

Inclusion criteria:	**Exclusion criteria:**
Literature type: Academic/published and gray (i.e. unpublished, government reports and documents, memoranda, theses, conference proceedings) material	**Literature type:** Sources which appeared partisan or biased, and did not identify and justify bias, and which did not meet basic standards of rigor (including an identified author or full details of the organization, date, sources of data credited and cited, reasonable spelling and grammar)
Language: English	**Language:** Languages other than English
Time period: 2005 – 2015, subsequently added to 2017	**Time period:** Years before 2005

If journal article, abstracts which contain the terms '**migrant**' AND '**health**', and one or more of the following key search terms identified: **policy, good/best practice, guidelines, programs, procedures**. For articles focused on CHW, abstracts which contain the terms '**CHW**' OR **'Community Health Worker'** and one of the following key search terms: **access, policy, good/best practice, guidelines, programs, procedures**. If web sources, the document was to contain the term '**migrant**' AND '**health**' and one or more of the following key search terms: **access, policy, good/best practice, guidelines, programs, procedures**.	Abstracts and/or web pages which do not contain any of the chosen search terms/phrases
Studies which specifically address migrant health in the form of policies, guidelines, best practices, discussions and/or recommendations, in South Africa and/or internationally	Studies which do not address migrant health in the form of policies, guidelines, best practices, discussions and/or recommendations, in South Africa and/or internationally

Figure 3.2: Qualitative Synthesis of 42 retained papers



3.2 INTRODUCTION: MIGRATION TRENDS, MIGRANT LIVES AND HEALTH

Migrants worldwide comprise a heterogeneous population that includes more than 214 million international and 740 million internal migrants (Betancourt, 2013). Although the field of public health has traditionally focused on how mobile populations contribute to communicable disease epidemiology, a growing literature exists globally on migration and health which includes mental health, reproductive health, and maternal and child health (Renzaho, 2014). These global studies have generally indicated that factors which drive migration will more closely determine a migrant's health, rather than the process of migration itself (Priebe, 2012; Betancourt, 2013). Increasing research has highlighted structural and institutional factors that affect migrant health, such as denial of medical care, access at the appropriate times, continued care for health conditions which require it, and an acceptable quality of care when available (Priebe, 2012).

This is a time of considerable mobility across the globe. According to the World Migration Report launched by the IOM, the estimated total number of international migrants constitutes over 3% of the global population (Suphanchaimat *et al*., 2015). Ideally, healthcare systems would adapt to ensure that primary care is culturally and linguistically appropriate for migrants (MacFarlane *et al*., 2014). However, although evidence-based guidelines, training interventions for cultural competence, and the use of professional interpreters are available across healthcare settings around the world, in practice migrants and their healthcare providers ‘get by’ with a range of informal and inadequate strategies which have often not proven to be effective (MacFarlane *et al*., 2014).

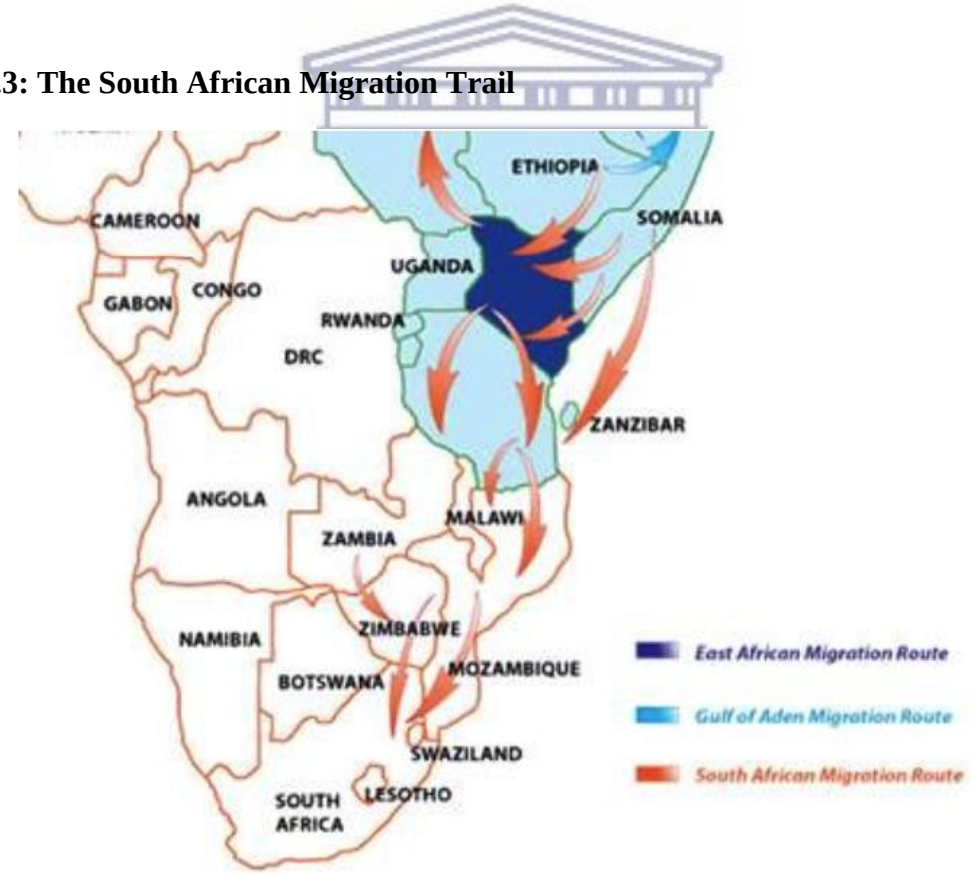
While in some settings migrants are healthier than the local population, as will be discussed later in this chapter, migrants in most situations are considered a vulnerable group with specific health needs (Hnilicová & Dobiášová, 2012). It is not difficult to understand why this is the case. Many face language barriers, cultural constraints, and discrimination; others also work in low-paying positions in high-risk sectors (Ibid). Their living conditions are often marginal, on the edge of poverty, which directly affects their health. Incidence of Tuberculosis in migrants has increased, although this is only one of many urgent health concerns deserving attention (Heldal, 2010). The WHO web bulletin, "Overcoming migrants' barriers to health" (http://www.who.int/bulletin/volumes/86/8/08-020808/en/) confirms the challenges mentioned in this section.

The 2010 statistics have shown that international migrants account for an approximate 3% of the world's population (Heldal, 2010). While migration is increasing on a global level in absolute terms, it has stayed constant at roughly 3% of the global population (UNFPA, 2015). In 2015, the number of international migrants worldwide reached 244 million (Ibid), which represented a 44% increase since 2000, and a steady 5% increase since 2013 (Ibid). Over the past 50 years there has been an increase in immigration due to globalization, socio-economic differences, and climate change, making health and migration a recognized issue in the public health sector (Heldal, 2010). Of the other motivations for movement, the most common have been escape from conflict and persecution, and the search for economic opportunities (Heldal, 2010; IOM, 2014), both of which have been relevant in South Africa's case. While a large amount of migration continues to be between and within developing nations, in recent times patterns are showing that migrants are also travelling to developed countries. Furthermore, there is

considerable movement between developed countries themselves (Heldel, 2010). While experiences vary based on patterns of travel, many challenges (health, economic, and social) faced by migrants everywhere are similar (Ibid).

Figure 3.3 below depicts the South African Migration trail, which describes the network of paths through East Africa down to South Africa. Migrants travel through a number of countries - Kenya, Uganda, Tanzania, Malawi, Zimbabwe, Botswana and Zambia – to get to South Africa. They migrate because it is a popular destination for economic migrants, with people throughout Africa moving to South Africa primarily in search of a better life (Segatti & Landau, 2011).

Figure 3.3: The South African Migration Trail



Source: International Federation of Red Cross and Red Crescent Societies 2017 Migration Trends and Community Resilience (retrieved October 2017)

As migrant numbers continue to increase, and they begin to start lives alongside local residents, their health impacts the health of the overall community. Hence, accessible high-quality healthcare services must be considered an urgent migration-related policy target. If governments want to protect their own populations, public health protection for migrants within their host country also needs to be a priority for all governments, and this is particularly essential for countries with high migration trends (Hnilicová & Dobiášová, 2012).

3.3 ACCESS TO CARE: REGIONAL AND COUNTRY EXPERIENCES

Policies governing access to healthcare services, specifically government-provided services, for migrants are a subject of debate, controversy and confusion. In theory, many countries have favorable laws promoting access to services for migrant populations. Albania, Bulgaria, Cyprus, Greece, Hungary, Italy, Malta, Portugal, Serbia, and Spain are a few examples in the European region (Chimienti, 2009; WHO, 2017). Similarly, the WHO European health policy framework, Health 2020, has drawn particular attention to migration and health, population vulnerability and human rights (Barnes, 2013; WHO, 2017).

The literature on Europe, however, has shown shortcomings in their policies. Grey and Ginneken's study compares the European situation to that of the United States. As of 2012, the total population of the 27 EU countries was more than 500 million, while the US's was cited to be approximately 300 million (Grey & Ginneken, 2012), and both have large and growing migrant population. In the EU, the estimated number of undocumented migrants ranged from 1.9 million to 3.8 million, which is substantially lower than the estimated 11 million to 12 million

cited for that time in the US (Ibid). However, for both the EU and the US, healthcare for migrants, particularly undocumented ones, has been concerning. In the US, attention is largely focused on migrants from Mexico and Central America, as that is where the majority of their incoming populations arrive from. The European migrant population is largely composed of people from Africa, the Middle East, and the former Soviet Union. Regardless of where people are migrating from, and despite laws being in place, many barriers continue to prevent migrants from accessing even the most fundamental health services. Among others, major access barriers include fear, lack of awareness of rights, and socio-economic status (Barnes, 2013; Woodward, 2013; Reyes-Uruenaa, 2014).

This section will present regional and country issues, challenges, and shortcomings. It will present Europe as a continent, and share examples of various European countries. This will be followed by examples from Kenya, China, Canada and South Africa. Alongside policies and regulations, some examples of practice and overall outcomes will also be presented where an issue is introduced.

a. Europe

The European Union has discussed the health needs of migrants in the context of its fundamental rights agenda (Hnilicová & Dobiášová, 2012; Barnes, 2013). The EU reports wanting migrants to integrate, participate in, and be consulted on matters which affect their health and their lives (Ibid). Hence, the EU has proposed that Europe's regional and municipal authorities set up migration-related forums and platforms where discrimination and inequities can be discussed (Ingleby, 2009; Hnilicová & Dobiášová, 2012). Despite this, many member states of the EU

continue to have healthcare integration policies which are discriminatory, and their migrant-related health legislation creates barriers to services (Pérez-Escamilla, 2010; Barasanti, 2013). As is commonly seen for all countries, implementation of most policies is often more challenging than the inception of that policy.

Even before the most recent waves of mass migration were provoked by the crisis in Syria and other events, European member states were facing a challenge in providing accessible and effective health care services for their growing migrant population (Ingleby, 2009; Devillé *et al*., 2011). It was unclear how best to achieve this, and there was debate on what would constitute good practice for European societies, given how multicultural they have become.

The article "Health care for immigrants in Europe: Is there still consensus among country experts about principles of good practice? A Delphi study" has assessed what constituted good practice after consulting with professionals working in various healthcare contexts across Europe (Devillé et al., 2011). The results and recommendations are relevant to countries even beyond Europe: (1) easy and equal access to health care; (2) empowerment of migrants (3); culturally-sensitive healthcare services; (4) quality of care; (5) patient/healthcare provider communication (6); respect towards migrants (7); networking in and outside health services; (8) targeted outreach activities; and (9) availability of data about specificities in migrant healthcare and prevention (Ibid). Although the local context of each country facing migrant healthcare access issues will vary, overall the nine points highlight what should be included in the policies and practices of all countries.

Europe has been a hub for large numbers of migrants coming from both developing and developed nations, and each European country has unique struggles when it comes to the issue of access to health services for this incoming population. In a 2014 study by the NGO Doctors of the World, it was documented that in London, 94.1% of patients who visited this organization's clinic had no previous access to healthcare coverage at all (Ingleby, 2009; Chauvin *et al*., 2015). This statistic is troubling, especially given that it comes in the context of the government questioning access to healthcare for undocumented migrants.

Both the UK government and judiciary have been reluctant to extend the fundamental human right to health to migrants who are illegal, or those who have failed the asylum process, and in particular to those who are living with HIV/AIDS (Davies, 2006; Barnes, 2013; Reyes-Uruenaa, 2014). Some countries have implemented innovative judicial practices with regards to the right to health for this category of migrants, but this has not been seen in the UK. In fact, it is documented that the Government's insistence that illegal migrants are abusing the National Health Service has led them to derogate from the right to health (Davies, 2006; Barnes, 2013; Reyes-Uruenaa, 2014). In England, of particular concern to health providers has been the impact of National Health Service charges on delaying HIV testing and anti-retroviral treatment uptake and adherence amongst certain migrant groups (Thomas, 2009). In other countries, similar ambiguities exist as migrants and healthcare professionals attempt to navigate through the system.

Certain findings from Europe have highlighted an important issue. A study conducted at a clinic in France and Belgium showed that a large number of their participants had never accessed

services or been to a clinic before the study - 92.3% in France and 89.9% in Belgium. In Greece, almost two thirds (61.5%) had never had healthcare coverage (Chauvin *et. al*., 2015). This is because foreign nationals, without permission to reside, in effect had no rights to any healthcare coverage at the time of these studies. In the Netherlands, 76.6% of patients seen in Amsterdam and The Hague could not obtain healthcare coverage due to their irregular administrative status (Ibid). Similarly, in Germany slightly more than two thirds (68.6%) of patients only had access to emergency healthcare. The current European migrant crisis has led to innovations in practice and new policy development in 2017 in countries such as Italy, Greece and Germany (World Health Summit, 2017), but these changes are not yet reflected in the literature identified for this review.

The Lancet-University of Oslo Commission on Global Governance for Health report (Ottersen *et al*., 2014) explains that there have been significant gains in health in the last few decades; however, health risks remain extremely unevenly distributed worldwide. The report goes on to state that while the health sector has a large role in addressing health inequalities, it is often faced with obstacles from global actors who have other priorities. While these other priorities are also important, they are different and include interests such as protection of national security, safeguarding of sovereignty, or economic goals (Ottersen *et al*., 2014). In Spain, almost 60% of patients seen only had access to emergency healthcare through emergency departments (Chauvin et al., 2015). An analysis of Spain's policies, however, indicates that they do include strategies to facilitate access to healthcare and reduce barriers for entry to the system by simplifying requirements, raising awareness, and improving communication and training methods for health staff (Chimienti, 2009; Vázquez, 2013; Reyes-Uruenaa, 2014). What is missing is sufficient

planning in terms of implementation, necessary resources, and evaluation (Ibid). Hence, it can be concluded that while the policies address relevant barriers to access for migrants, and indicate improvements in the health system's responsiveness, reinforcement is required in order for them to be effectively implemented, and that is currently missing from the system (Vázquez, 2013; Reyes-Uruenaa, 2014).With 1 billion people on the move globally, 244 million of whom have crossed international borders, there is a recognized need to strengthen efforts towards implemented and accessible universal health coverage (Hanefeld *et al*., 2017). The interactions between migration, mobility, and health are complex, but acquiring a clear understanding of how to respond is vital (Ibid).

Migrants represent approximately 8.7% of the resident population in Italy (Barasanti, 2013; Sulis *et al*., 2014), and migrant status deeply influences access to prevention and care. Despite migrants being allowed access to care in theory, as in South Africa, a study on healthcare access for migrants in Italy showed that foreigners and foreign-born people suffer from unequal access to healthcare services (Vazquez, 2011; Devillanova, 2012; Barasanti, 2013). They are more likely to contact emergency services and less likely to visit specialist doctors and use preventative care. Similar results appeared for second-generation migrants, who displayed a lower probability of visiting specialists and also had higher hospitalization rates than those who were generationally from Italy (Devillanova, 2012; Barasanti, 2013). Thus, there are gaps in the care that migrants receive in developed countries. Delayed diagnosis of health conditions, particularly those requiring immediate detection and ongoing treatment such as HIV and TB, represent a significant problem (Sulis *et al*., 2014), and an increase in the burden of diseases such as HIV/AIDS has been seen among this population. Undocumented migrants and foreign-born

individuals are not being diagnosed early, and access to care continues to be a challenge (Ibid). As the migrant population is increasing, this requires attention (Ibid).

While most countries, including the EU nations, have policies which support healthcare access for migrants (documented and undocumented), this remain haphazard in practice (Vazquez, 2011; Woodward, 2013). Priebe et al.'s work on good practice in healthcare for migrants has identified the eight main problems that migrants face in accessing services, despite favourable policies being in place (Chimienti, 2009; Priebe *et al*., 2011; Reyes-Uruenaa, 2014). These are language barriers, difficulties in arranging care for migrants without healthcare coverage, social deprivation and traumatic experiences, lack of familiarity with the healthcare system, cultural differences, different understandings of illness and treatment, negative attitudes among staff and patients, and lack of access to medical history (Chimienti, 2009; Pérez-Escamilla, 2010; Priebe *et al*., 2011; Reyes-Uruenaa, 2014). The findings chapters will show that these difficulties are similar to those found in this research.

b. Africa: Kenya

In recent years, Kenya, and particularly its capital city Nairobi, has experienced an increase of international economic migrants (Arnold, 2014; Van de Vijver, 2015). They have also received migrants who were forced to flee their neighbouring countries of origin, and those from UNHCR-managed refugee camps (Arnold, 2014; Van de Vijver, 2015). Hence, the issue of migrant access to health services is one of relevance and importance in the Kenyan context.

The number of refugees in Nairobi was estimated at over 100,000 in 2014 (Mohamed *et al*., 2014). The constant movement of this population between countries of origin, refugee camps,

and Nairobi poses risk of introduction and transmission of communicable diseases, as well as raising concern about continuity of care for this mobile population. In this regard, Kenya faces similar challenges to the other countries in Africa.

The most widely-cited barriers to accessing care include long waiting times, lack of drug availability, transportation, and cost (Arnold, 2014; Van de Vijver, 2015). These are experienced by both locals and migrants. Barriers which only migrants uniquely have been said to face include the threat of harassment, cost discrepancies between migrant and Kenyan patients, real or perceived discrimination, documentation requirements, and language barriers (Arnold, 2014).

Healthcare in Kenya is provided by government and non-governmental organizations. This includes Kenya's Ministry of Health, local government authorities, and religious organizations (Mohamed *et al*., 2014). Along with this, the private healthcare system in Kenya has grown over the last two decades, due to lack of adequate and quality public healthcare services (Mohamed *et al*., 2014). User fees for some service at public facilities have also been introduced, further deterring usage (Ibid). However, this continuously growing private health sector is not regulated.

One example of this was documented through a multi-country study using focus groups, consisting of 70 migrants from the southern African region (Thomas, 2009). The migrants' confusion, alongside financial difficulties and fears over deportation, was often cited as a factor influencing their decisions to avoid formal health services (Thomas, 2009; Van de Vijver, 2015).

As a result, many migrants resorted to alternative and often ineffective or potentially adverse forms of therapy, and delayed HIV testing and treatment (Thomas, 2009).

Despite articles from the 2010 Constitution of Kenya that declare the right to health for every person in the country, migrants continue to experience barriers in accessing healthcare (Arnold, 2014). While they are not barred from accessing healthcare in government-run facilities, studies have reported that refugees may have anxiety about receiving services from government officials because of policies requiring them to remain in migrant camps (Pavanello *et al*., 2010; Van de Vijver, 2015). Similar concerns may be driving migrants to seek care at informal or private facilities, or to self-treat (Ibid). Along with this, fear of government authorities and perceived low quality of healthcare services have also been cited by studies as reasons for why migrants tend to avoid government facilities (IOM, 2011).

c. Asia: China

China has seen an increasing trend in migration, particularly internal migration. However, there is no national-level health insurance system in the country (Milcent, 2010). In fact, the right to healthcare insurance and other benefits depends on a permanent residence registration system. Thus, individuals are restricted to claiming medical care benefits only in the location where they are registered (Ibid). This poses a major challenge for the migrant population as they move from towns to cities for work. Not only are they excluded from urban public health insurance, but they also have to return to their place of registration in order to take advantage of the rural public health insurance (Ibid). Due to these legislative factors, migrants are effectively excluded from healthcare access.

Studies have shown that as long as migrants do not consider their health problems to be an issue in terms of job performance, they may ignore them (Milcent, 2010). When the gravity of their condition becomes an issue for their work, they react. However, reacting does not necessarily mean a visit to a medical facility (Ibid). In the case of China, the system excludes them from healthcare access unless they return to their hometowns (Ibid).

In response to increased migration from different parts of the country (primarily rural to urban), China has expanded its health insurance coverage (Yip, 2008). However, financial protection remains insufficient for both migrants and their families. While in the past, studies were focused on whether there was available coverage for migrants (Neilsen, 2005), now the concern is also whether the available plans and health services benefit the population, given its high mobility and set of health risks. With no comprehensive or universal medical coverage for migrants at the national level, or even at a local level, access is a constant challenge (Ibid). The private health insurance systems are not affordable to all, and contain many restrictions, such as age and employment (Ibid).

d. Canada

In developed countries such as Canada, there are several concerns associated with providing healthcare to refugees. As in South Africa, healthcare is a provincial jurisdiction, although the federal program intersects with provincial programs and prerogatives. The refugee healthcare domain remains an inherently complex issue, and it spans numerous sectors, impacting many groups and organizations interested in reducing migrant health outcome disparities (Antonipillai, 2015).

The Interim Federal Health Program (IFHP) policy is the refugee health policy in Canada that was established in 1957, aimed at promoting the health and well-being of asylum seekers and refugees. The program was intended to provide emergency and essential health coverage before refugees are considered permanent residents, as they are not eligible for provincial health insurance until that time (Canadian Council for Refugees, 2012). The IFHP provides necessary health insurance to improve the livelihoods of countless refugees. Ultimately, its expected impact on health depends on its provision of access to adequate healthcare services, and there is debate about whether access is sufficiently available (Antonipillai, 2015).

3.4 SOUTH AFRICA

There is still considerable ambiguity around how migrants and healthcare professionals navigate the system in most countries, and countries in Africa are no exception. It has been over 20 years since South Africa transitioned from apartheid to a constitutional democracy, and considerable social progress has taken place over these decades (Benatar, 2004; Coovadia *et al*., 2009; Whiteside, 2014).Yet the health and well-being of populations in South Africa remain plagued by a persistent burden of infectious and non-communicable diseases, ongoing social disparities, and inadequate human resources to provide care for a growing population, which includes large numbers of migrants from neighboring African countries (Mayosi, 2012; Whiteside, 2014). In fact, South Africa continues to have one of the worst tuberculosis (TB) epidemics in the world, while the spread of HIV infection in recent decades has considerably worsened the situation (Churchyard, 2014). The incidence of TBs increased from 300 per 100,000 people in the early 1990s, to more than 600 per 100,000 in the early 2000s (Churchyard, 2014). In 2012, the

statistics showed it to be more than 950 per 100,000 (Ibid). Both the local and migrant populations are heavily affected by this.

The South African Constitution (Act 108 of 1996) theoretically guarantees access to care for everyone in the country, including migrants. In practice, the findings reported in this thesis, as well as the literature reviewed, have shown that this guarantee has not been realized. A combination of reasons has contributed to this gap between policy and practice. Many of the state hospitals across the country are in a state of crisis (Von Holdt & Murphy, 2006), as the public healthcare infrastructure is in poor physical condition and dysfunctional due to mismanagement, insufficient funding, and overall neglect. While this has been most clearly visible in the Eastern Cape province (Health Systems Trust, 2013), other regions including the Western Cape, where this study is based, have seen the same (Coovadia *et al*., 2009; Mayosi, 2012). To date, heavy emphasis has been put on legislation and biomedicine as the dominant routes to improve access to health (Mayosi, 2012). However, what require urgent consideration are the social determinants of health. Without understanding the complexity associated with the effective practical application of these laws, health services will not improve (Ibid). Migrants face many barriers, as presented throughout this thesis, which must be addressed before constitutional guarantees can be realized on the ground.

3.4.1 From Legislative Theory to Practical Access in South Africa

Recent estimates suggest that between 3 and 4% of South Africa's population are non-nationals, and have migrated for livelihood purposes (Statistics South Africa, 2012; Moultrie *et al*., 2016). Cross-border migrants have come from other sub-Saharan African countries (Statistics South

Africa, 2012; Moultrie *et al*., 2016), and another approximately 7% of the population (3.7 million) are internal migrants, who have moved between South Africa's nine provinces (Moultrie *et al*., 2016). Despite this data, the existence of government policies, and ample evidence highlighting the frequency of diverse population movements within the country, public healthcare services still rarely engage with mobility or migration in any form (Vearey, 2014; Walls *et al*., 2015).

Human Rights Watch (2008), as well as NGO and media reports, have described a significant gap between South Africa's inclusive policies and the reality of access to healthcare for refugees, asylum seekers, and especially undocumented migrants (Amon & Todrys, 2009). Some public clinics demand South African identification documents before allowing patients any care (Ibid), which has led to denial of treatment for those without identification papers. Similarly, asylum seekers have experienced continuing difficulties accessing Anti-Retroviral Therapy (Consortium for Refugees and Migrants in South Africa, 2008; AIDS Law Project *et al*., 2008). Furthermore, human rights organizations, researchers and the media have documented verbal abuse, poor treatment, insensitivity by health care professionals, unusually long wait times, and finally outright denial of services facing migrants seeking healthcare (Federation International des Droits de L'Homme - FIDH, 2008; Amon & Todrys, 2009; Barnes, 2013). Some migrants are illegally charged fees for treatment or medication, while others are told that they must be a South African citizen and carry a green citizenship card if they want to use even basic services (Amon & Todrys, 2009).

Zimbabwean migrants are among the largest migrant groups entering South Africa. Undocumented Zimbabweans in need of healthcare have often had to turn to South African charities and churches (Human Rights Watch, 2008), since they have been turned away from government clinics because they were unable to present legal papers. Theo Smart's article shared that Basotho mineworkers have faced deportation and even been left at the border of their home country, due to being infected with HIV and multi-drug resistant tuberculosis (MDR-TB). They would be put in this situation without any treatment or referral to local health services for treatment (Smart, 2008; Barwise, 2013). While Zimbabweans leave home due to financial hardships and other difficulties, research shows that their lives in South Africa are characterized by struggles which are foreign to them, and traumatic to many (Idemudia *et al*., 2013). There is a psychological and physical toll of migration that they are not able to avoid (Ibid). Idemudia et al.'s study puts forth the recommendation of advocating for culturally congruent health research and services, including a focus on mental health (Ibid). The importance of training culturally competent researchers and clinicians is also emphasized (Ibid).

Somalis are another large migrant group in South Africa. Amongst other social and economic difficulties, they have experienced challenges in accessing healthcare, facing issues relating to the inhospitable treatment by hospital staff, which in most cases has been attributed to xenophobia (Pophiwa, 2009). Language barriers have also caused issues for them in accessing care. Somali participants described medical procedures which they did not give consent to perform, such as tubal ligation (Hunter-Adams & Rother, 2017). In instances where a migrant's partner spoke the language, they interpreted for the patient (Ibid). However, these situations have also led to non-professional medical interpretations, and income loss while away from work to

assist with communication (Ibid). Somali participants have expressed fears over being unable to access care, or being mistreated (Ibid).

Since the Constitutional recommendations are included in all government-initiated healthcare policies (presented in Chapter 4), most of the documented work on migrant healthcare access in South Africa has found it essential to look at understanding the flaws in providing healthcare to undocumented migrants (Pophiwa, 2009). This research interest stems from the fact there is a stark and problematic difference between South African government policies and the reality for migrants on the ground.

3.4.2 Challenges for Women Migrants in South Africa

Half of the world's estimated 95 million migrants are women and girls, and migrant women have special health needs. Although the South African Constitution guarantees the right of access to healthcare for all, in practice the process is covered in uncertainty and many migrants do not access healthcare for fears of being asked for official documentation, and deportation (Munyewende *et al*., 2011). In addition, xenophobic violence, insensitive health workers, and social exclusion often prevent migrants from seeking required medical attention (Ibid). Migrant women's increased risk of sexual violence further raises their chances of acquiring sexually transmitted infections (STIs), including HIV (Ibid). Thus, deferring or denial of healthcare has public health implications not only for the migrant population but for broader society, as the costs of transmission of infectious diseases, disabilities, and chronic illnesses are high (Ibid).

3.4.3 Initiatives by Intergovernmental and Non-Governmental Organizations in South Africa

Health and migration-related organizations also have a responsibility to assist with better health access. The IOM is often involved with programs assisting with migrant healthcare issues. One example is the Ripfumelo program, which ran from 2009 - 2012, where government officials and civil society in Musina (South Africa) were educated on increasing migrants' access to health services, as well as finding solutions to challenges relating to their health (IOM, 2009). The USD 5.1 million USAID-funded project aimed to provide sustainable HIV prevention and care services to migrant farm workers (IOM, 2009). They did this by developing a network of stakeholders working specifically on HIV-related issues to reduce the high incidence and impact of AIDS on migrant farm workers, their families and communities (IOM, 2009).

Médecins Sans Frontières (MSF) has also been actively involved with important initiatives serving the migrant population, as is evident on their website (http://www.doctorswithoutborders.org). Zimbabweans continue to cross the border into South Africa daily in large numbers, legally and illegally. For many, there is no access to proper healthcare, shelter or safety (MSF, 2009). In 2007, MSF opened two projects to serve this population and their specific health needs. MSF mobile clinics, operating in and around Musina town at the border with Zimbabwe, provide general primary healthcare (Ibid). They also provide referrals to existing hospitals or specialized medical facilities, including humanitarian assistance such as shelter, water and food (Ibid). There is also a fixed MSF clinic at the Central Methodist Church in Johannesburg (Ibid).

Zimbabweans attending MSF clinics in both Musina and Johannesburg have explained that they faced significant barriers trying to access public health structures. While there are thousands more Zimbabweans, often illegal, who do not come forward to access services due to fear of being deported, MSF medical teams treat 4,000-5,000 Zimbabweans each month (Ibid).

Another noteworthy project initiated by MSF in 2016 is situated in Khayelitsha, near Cape Town. In Khayelitsha and nationally, MSF has worked hardto secure access to new TB drugs for eligible patients, which includes migrants (MSF, 2017, www.msf.org.en/where-we-work.south-africa). South Africa now has national access to the new TB drug, Bedaquiline (Ibid), and in Khayelitsha, MSF has the largest national cohort on another promising new medication, Delamanid, with 61 new patients initiated on treatment in 2016 (Ibid). MSF also supports the Western Cape Department of Health to offer 'strengthened treatment' regimens to drug-resistant TB patients (Ibid), emphasizing the need for non-governmental and governmental organization collaborations.

All programs mentioned here are innovative and have shown to be effective at the pilot or local level. The next step would be to evaluate the feasibility and mechanisms of possible scale-up.

3.5 UNDERSTANDING DIVERSITY IN EXPERIENCES

In addition to differentiating between migrant health experiences in different countries, there is diversity in experiences even within a population of migrants in a given country, and some face harsher challenges in accessing health services than others. For example, sex workers in the

migrant population of many communities are shown to have worse health than the rest of their migrant counterparts (Goldenberg, 2014). In the sex-trade, mobility and migration are shown to correlate with reduced control over sexual negotiation with intimate partners, and reduced healthcare access (Ibid). In the study cited, mobility for sex work was associated with enhanced workplace violence (both sexual and physical), suggesting that mobility/migration may promote risks through less control over work environment, and isolation from health services (Ibid). As a potential response to this, structural and community-led interventions include policy support, which allows for more formal organization of sex work collectives. It also allows for access to workplace safety standards, which remain critical to supporting health, safety, and access to care for sex workers who belong to the migrant population (Ibid)

3.6 RECOMMENDATIONS FROM KEY ORGANIZATIONS, CONFERENCES AND GOVERNING BODIES

In the face of an increase in migrant numbers, there is a demand for a reorientation of health policies to better protect migrants' health. A number of high-level health-related international activities/meetings can be cited to showcase essential initiatives in the past few years. In 2006, the United Nations General Assembly (UNGA) Global Commission on International Migration high-level dialogue called for a more collaborative and cohesive global response to the challenges of migration (Chimienti, 2009; Suphanchaimat, 2015). In 2009, the Program Coordination Board of the Joint United Nations Programme on HIV/AIDS held its 24th meeting in Geneva, highlighting HIV-related needs for people on the move (Ibid). The Board also articulated that the improvement of HIV information and services for migrants would support the development and implementation of international healthcare strategies. Thus, there is a shift in

the areas of focus for the health of migrants, which has expanded from disease-specific care to health promotion and disease prevention (Ibid).

In 2010, the 1st Global Consultation on Migration and Health took place in Madrid, Spain. It was organized by the WHO and the IOM in Madrid, and resulted in a global framework for action. As a consequence of the rapid increase of migration in recent years, the topic of health and migration has gained attention in the discussions of the WHO Executive Board and World Health Assembly (WHO, 2016). The 2nd Global Consultation on Migrant Health: Resetting the Agenda was held in February of 2017, jointly organized by IOM, WHO and the Government of the Democratic Socialist Republic of Sri Lanka. It offered Member States and partners a meaningful platform for multi-sectoral dialogue and political commitment to enhance the health of migrants (IOM, 2018). Another important convention, the WHA Resolution – Promoting the Health of Refugees and Migrants, took place in May of 2017. Urging Member States to promote the framework of priorities and guiding principles to advance the health of refugees and migrants, it was co-sponsored by 14 countries: Argentina, Colombia, Ecuador, Greece, Haiti, Italy, Luxembourg, Mexico, Panama, Philippines, Portugal, Switzerland, Thailand, Zambia (WHO, 2018).

In 2008, the WHO member states adopted the World Health Assembly Resolution on the Health of Migrants (61.17), and recommended the integration of migrants' health needs into broader frameworks on migration and development (Schneider, 2014). Despite this resolution, and recognition by the international development community that "health is central to sustainable development" (WHO, UNICEF, Government of Sweden and Government of Botswana, 2013),

migrant health has received little attention in the migration and development debate (Schneider, 2014:2). Of the six Global Forums on Migration and Development (GFMD) held since 2007, migrants' health was only discussed in 2010 in Mexico, during discussions on reducing migration-related costs, which led to the recommendation that governments and partners should "assess cost-effective healthcare models for various types of migration scenarios" (Schneider, 2014:2). However, to date there has been minimal comprehensive follow-up on this.

In 2006, the IOM and East African Community (EAC) decided to collaborate on developing regional health programs which were aimed at promoting the health of migrants, and particularly hard-to-reach, displaced, and mobile populations (IOM, 2006). Management of the migrant population has been a longstanding concern for the African community at large, and regional collaborations are common and admirable. In 2014, migrants were the focus of the first East Africa International Authority on Development (IGAD) Scientific Conference on Health, which took in Addis Ababa, Ethiopia (IOM, 2014). The key objectives of the conference were to share knowledge and best practices on health among migrant populations, and to dictate new directions and policy orientations for accelerated and sustainable delivery of health services (IOM, 2014). It was also to enhance cooperation between a wide range of partners (Ibid). While each of these initiatives, and dozens of others such as these, are much needed, it is essential to evaluate them to gauge how impactful they are. Monitoring and evaluation of current and past programs are also lacking, and must be prioritized in order to mitigate shortcomings and plan more effectively for the future (Ibid).

However, the health of migrants was not on the agenda of the 2006 High Level Dialogue (HLD) on Migration and Development, nor was it a point of discussion at the HLD in October 2013 (Ibid). Within the Global Migration Group (GMG), migrant health is rarely addressed, and even though the WHO joined the group in 2010 and many GMG agencies carry out significant health programmes, migrant health has been neglected (Ibid). It is essential that this topic become a part of discussions, policy making, and practices.

Policies governing access to healthcare services for migrants, and specifically government-provided services, were a subject of debate, controversy and confusion even as recently as in 2015. In England for example, of particular concern to health providers has been the impact of National Health Service charges on delaying HIV testing and anti-retroviral treatment uptake and adherence amongst certain migrant groups (Thomas, 2009; Chimienti, 2009). In other countries, similar ambiguities exist as migrants and healthcare professionals attempt to navigate through the system.

In line with this, the annual European Public Health Association (EUPHA) Conference in 2014 emphasized the need for adaptation of health promotion and disease prevention interventions for migrants and ethnic minority populations (Suphanchaimat, 2015). Furthermore, the WHO has acted as a catalyst for various stakeholders in addressing the health of migrants. Its work is visible through a number of relevant World Health Assembly Resolutions (WHR). One to note is WHR60.26 on 'Workers' health, global plan of action', encouraging member states to work towards full coverage of all workers, including migrants. Along with this, WHR61.17 on 'Health of migrants' called for migrant-sensitive health policies and practices (Norredam, 2011;

Suphanchaimat, 2015). Each of these initiatives is noteworthy, and come at a time where the health of migrants is an urgent matter.

When a migrant patient accesses a physician for treatment, particularly within a primary care practice, it can be difficult to diagnose that patient and understand what health issues may be relevant to them without knowing more about their background, both health-wise and in terms of nationality (Wagner, 2011). Certainly, the practitioner may face an unfamiliar situation, but migrants themselves may also have come from countries with almost non-existent health systems, or systems which are very different from their current host country. A migrant's expectations of healthcare in their new home can be influenced by their experiences of the health system in their country of origin (Wagner, 2011). Therefore, being aware of this fact, and understanding the current system, can reduce confusion during migrants' medical experiences. Information and resources to help practitioners care for migrant patients have been brought together in an online resource called the Migrant Health Guide (www.hpa.org.uk/migranthealthguide) (Ibid, 2011). The guide also includes country-specific information, and was launched by the Health Protection Agency in January of 2011. It covers a range of relevant topics, including infectious diseases as well as other health concerns, such as anemia, dental care, and mental health (Priebe, 2012). The guide also outlines which tests are recommended for particular countries of origin. Initiatives such as these are assisting in bridging the gap between migrants and successful healthcare experiences.

Regulations regarding eligibility for services for various categories of migrant are extraordinarily complex, and often misunderstood by patients and providers alike (Fennelly, 2007). A documented recommendation for physicians is to take steps to ensure that their patients are not denied services for which they are eligible, and that patients are not reluctant to come in for care because of the belief that their confidentiality and security will be violated (Ibid). Physicians should also educate others within the healthcare system of the complexities of eligibility and barriers that they pose to migrants. As awareness of barriers improves on both ends, access may become easier and utilization may consequently increase (Ibid).

3.7 CONTINUED CHALLENGES IMPACTING MIGRANT HEALTH AND FURTHER RECOMMENDATIONS

Research has highlighted structural and institutional factors that affect migrant health, such as access to medical care, access at the appropriate times, continued care for health conditions which require it, and an acceptable quality of care when available (Scheppers, 2006). However, several barriers limit access to health services among migrants. These include ethnicity, age, poverty, education, language skills, legal status, area of residence, isolation, access to transportation, and culturally competent service providers (Ibid). What is important to remember is that the health of migrants cannot be kept isolated from the health of the general population. Migrants are disproportionately affected by the lack of access to essential healthcare services, including primary care, immunizations, pre-natal care, and routine health screenings (Ibid). Healthcare access for migrants is a major concern in many developing nations (Suphanchaimat *et al*., 2014). South Africa still has the largest population of people living with HIV globally, and the country is characterised by high population mobility (Vearey *et al*., 2011). The majority of

migrants come in search of better economic opportunities, and many who migrate both internally and across borders settle into urban areas, often in peripheral informal settlements, where HIV prevalence is shown to be double that of urban formal areas (Ibid). Thomas *et al*.'s article suggests that confusion over healthcare entitlements exists amongst those seeking healthcare, and is also reported amongst health service providers (Thomas *et al*., 2010). However, there is little evidence suggesting that the current health systems effectively address the issues of migration, livelihood challenges, and HIV (Barwise, 2013; Suphanchaimat *et al*., 2014). More in-depth studies must be undertaken to further explore those knowledge gaps, and gaps in policies and practices.

3.7.1 Millennium Development Goals

Although there are an estimated one billion people currently living outside their place of origin (Schneider, 2014), the Millennium Development Goals, which ended in 2015 but were an important framework for health and health system work at the time of this study, did not identify migrants as a vulnerable group in need of protection. Some migrants are still within their own countries, while others are across borders. Migration has become a key livelihood strategy for many families, yet their health is still not being prioritized as required (Schneider, 2014). Thus, it was hoped that the post-2015 development framework will recognise them as a significant population with health needs (Ibid). The Sustainable Development Goals (SDGs) offer scope for better addressing migration (Taran *et al*., 2016) as they have the potential of supporting health for migrants through Goal 3 (Good Health and Wellbeing) and Goal 10 (Reduced Inequalities).

3.7.2 Challenges Unique to Migrant Women

It is also important to understand migration from a gendered perspective, as males and females have different reasons for and experiences of migration. Studying only the social or economic reasons for migration tends to overlook the complexity of the issue for female migrants (Institute of Social Studies Trust India, 2014).

For example, in the 1980s, Japan, Hong Kong and Singapore, followed a decade later by Malaysia and Thailand, were all high-performing economies which imported migrant workers for gendered reasons (Asis, 2004). While men were imported to work in the construction sector, plantations, and the fishing and rice mill industries, female migrant workers were limited to domestic work in Hong Kong, Singapore, and Malaysia, and entertainment in Japan (Ibid). Similarly, once the labor market opened to women in the Middle East in the 1990s, migrant women were encouraged to take jobs in the service industry (mostly as domestic workers), and the sales and professional (e.g., medical personnel) sectors (Ibid). The Philippines, Indonesia and Sri Lanka became the major source countries of domestic workers (Ibid).

Available research has shown that women typically cite familial reasons for migration (Ibid). For example, in the South Asian context, most women recorded as migrants have explained migrating due to exogamous marriages, with only a very small proportion migrating primarily for economic reasons (Sadhna, 2006). In contrast, male migration has largely been regarded as for economic reasons (Ibid). However, in the South African context, this study has shown that women migrate primarily for economic reasons. It can therefore be concluded that women in different parts of the world migrate for different reasons.

Migrant women who are pregnant also face many unique issues when trying to access services in their host countries. Research has asked pregnant migrant women to identify several categories of interventions which they would have liked to use, and recommendations for the creation of programs. These include considering income and social status when building programs, making social support networks available, educating pregnant women on what services they have at their disposal, explaining personal health practices and coping skills, educating them on healthy child development, and on health services for their babies (Gagnon, 2013; Ruiz-Casares *et al*., 2013; Renzaho, 2014). Within each of these, the most common suggestions were related to creating supportive environments, and building a public health policy which extends to them as migrants, both legal and illegal (Norredam, 2011; Gagnon, 2013).

Interestingly, ethnicity has an important relationship with most health indicators for mothers, regardless of their country of birth, length of residence, and socio-demographic circumstances (Jayaweera, 2010; Renzaho, 2014). Once adjusted for ethnicity and socio-demographic variables, association with birth abroad disappears for most health outcomes, which suggests that there may not be an independent migrant penalty in health (Jayaweera, 2010; Ruiz-Casares, 2013; Renzaho, 2014). This suggests that while there are continuing barriers to good health for migrants in their new host society, factors important for one health outcome may not apply to another (Ibid). Hence, there is a strong need for a comprehensive collection and analysis of information for all categories of migrants for understanding patterns of and factors underlying health and use of healthcare services (Ibid).

3.7.3 Education for Migrants and Training for Health Professionals:

The documented literature on policies and guidelines which impact on migrants' access to healthcare explains that a number of efforts can be made, including policy-level interventions, strengthened networks and partnerships, improved migrant-sensitive services, and continued research in migrant health (Norredam, 2011; Arnold, 2014). Emphasis should also be placed on educating migrants how to navigate through the health system, since often their lack of knowledge leads to delays in seeking medical attention. Also, they need to be informed about preventative services, so that their cases do not become extreme or requiring frequent visits to emergency care (Mujica-Martorell, 2012). Another strategy is creating hospitals or healthcare clinics targeted specifically towards disadvantaged migrant populations, and being sure to offer truly free care (Ibid).

Along with this, an essential strategy is having health professionals and institutions who collectively cover multiple languages, and work to increase intercultural knowledge (Norredam, 2011; Mujica-Martorell, 2012). While some countries have multiple official languages which are used in the service sectors, language has frequently been cited as a major obstacle to obtaining satisfactory healthcare (Norredam, 2011; Mujica-Martorell, 2012). Along with language, cultural issues have also been noted as a factor which hampers communication in consultations between health professionals and migrants, with a range of negative effects, including poorer compliance and a greater propensity to access emergency services (Van den Muijsenbergh, 2014). It is well established that there is a need for both skilled interpreters and for professionals who are culturally competent to address this problem (Ibid). Although a range of professional guidelines and training initiatives exist, supporting communication in cross-cultural consultations in

primary care, these are commonly not implemented in daily practice (Norredam, 2011). Jensen *et al*. highlight the overall importance of training care providers with the context, knowledge and skills required to serve diverse migrant populations (Jensen *et al*., 2011). The reasons why professionals are not yet implementing mandated guidelines or interventions are not known, and further research on this topic is therefore important.

3.8 THE HEALTHY MIGRANT PHENOMENON

A growing body of literature describes the 'healthy migrant' phenomenon, the fact that, on a variety of measures, migrants are often healthier than the native-born residents of their new host countries (Fennelly, 2007). Over time, however, the migrant health advantage diminishes dramatically. The policy implications of the healthy migrant phenomenon are significant. First, it diminishes the arguments of some anti-migrant groups that migrants pose a health threat to the host population (Fennelly, 2007; Norredam, 2011). Secondly, it illustrates that the most economically sound policies would be to invest in services to maintain the good health of this important and growing segment of the population, rather than to continue to cut benefits and create barriers to preventive care (Ibid). To do otherwise will prove far more costly in the long run, and most countries cannot afford the possible burden of diseases that this may bring.

Some literature shows that migrant groups in general experience poorer health compared to that of the local population. For example, Gerritsen and Deville explain that restrictions in access to healthcare services is one reason why that may be the case (Gerritsen & Deville, 2009). This poorer health may result from adverse socio-economic status, cultural factors (e.g. a different

perception of health), or biological factors (e.g. genetic factors). Furthermore, differences have been reported in healthcare utilization between migrant groups and the local population. These differences vary according to the type of healthcare service utilized (e.g. general practitioner, specialist, hospitalization), and between different migrant groups (Ibid). The differences may be partly explained by variations in age, gender, socio-economic position, health status, and ethnicity, but there are many factors which restrict migrants from using health services, and some are more complex than others (Ibid). These include health beliefs and attitudes, language, family and social support, physicians' skills and attitudes toward minority patients, and familiarity with the healthcare delivery system (Ibid). Migration is therefore a key determinant of health, and it demands policy and programs which are effective and appropriate (MacPherson & Gushulak 2001; Anarfi 2005; Vearey, 2010).

The Southern African Development Community (SADC) member states and the Millennium Development Goals (MDGs) demand a focus on the health of internal and cross-border migrant populations (Vearey, 2010), and a process of healthy migration needs to be facilitated if the full potential and development benefits of migrants can be achieved. This requires that a public health approach to migration be taken, especially within the SADC region. All levels of government within SADC member states will need to be involved in including internal and cross-border movement into their policies and programs, if a process of healthy migration is to be achieved (Ibid). Without it, migrant populations may not be able to access positive social determinants of health (SDH). And this includes access to the public healthcare systems, which many migrants do not utilize. SADC is a region which is home to both high population mobility

and also a high prevalence of communicable diseases (Ibid). Hence, while prioritizing migration and health is of high relevance to all countries, it is of particular relevance to this region.

3.9 COMMUNITY HEALTH WORKER CONTRIBUTIONS TO FACILITATING ACCESS FOR MIGRANTS

As a result of the continuous shortage of human resources for health, combined with an increasing burden of disease in recent years, community health worker (CHW) programs have received considerable attention from the health sector and other institutions involved in providing care (Perry *et al*., 2014). The shifting of tasks from more to less specialized health workers is taking place in many lower and middle income countries, and these tasks are often extended to CHWs (Chopra *et al*., 2008). However, the role of CHWs in migrant access to healthcare has received very little attention in the literature. Only six out of 104 retained papers for this scoping review directly addressed CHW in relation to migrant health. They are listed below (full citations are found in the reference list):

1. IOM (2005). Community Health Volunteers: Ines's Story.

2. Brownstein *et al*. (2011). Community health workers "101" for primary care providers and other stakeholders in healthcare systems.

3. Dobrzycka (2008). Applying the Community Health Worker Model to the Immigrant and Refugee Population in Pittsburgh, PA.

4. Oliver *et al*. (2015). What do community health workers have to say about their work, and how can this inform improved program design? A case study with CHWs within Kenya.

5. Torres *et al*. (2013). Community health workers in Canada: innovative approaches to health promotion outreach and community development among immigrant and refugee populations.

6. Islam *et al*. (2013). Evaluation of a community health worker pilot intervention to improve diabetes management in Bangladeshi immigrants with type 2 diabetes in New York City.

This section therefore draws on other literature on community health workers to introduce this important theme.

CHWs act as intermediaries between communities and the health sector (Lewin *et al*., 2010). While they are usually not officially employees of the Department of Health, they play a significant role in promoting the well-being of the populations they serve, and therefore form an essential group of health workers in many low- and middle-income countries (LMICs), including South Africa. While some duties vary from community to community, the core CHW roles are similar in most communities where they exist, and include delivering promotive, preventative, and at times curative health services (Ibid). Thus, CHWs are meant to facilitate entry into the system. They are community members who serve as frontline healthcare professionals in the communities where there is need (Love *et al*., 1997; Oliver *et al*., 2015). This need is often based on geographic constraints, lack of resources, and a diverse and large population which can benefit from the additional support. They generally work with the underserved, and typically belong to the community in which they work, ethnically, linguistically, socioeconomically, and experientially (Ibid).

As health systems globally strive to function efficiently, and encourage preventative and primary care, they also aim to improve quality of care and overcome non-financial barriers to care (Witmer *et al*., 1995; Oliver *et al*., 2015), and community health workers have been identified as having the potential to further these goals. In an ideal situation, CHWs can increase access to care and facilitate appropriate use of health resources by providing outreach, and cultural linkages between communities and delivery systems (Ibid). They can also reduce costs by

providing health education, awareness, screening, detection, and basic emergency care (Ibid). Furthermore, they can improve quality by contributing to patient-provider communication, continuity of care, and consumer protection.

Thus, their potential and roles are extensive, if they receive the training and support required to perform their functions. CHWs often face poor motivation, high workloads, and varying quality and expectations, which can result in sub-optimal effectiveness (Glenton *et al*., 2013; Perry *et al*., 2014). In order to better integrate them into the healthcare delivery system, information sharing, program support, program evaluation, and continuing education are needed to expand the use of community health workers (Witmer *et al*., 1995; Oliver *et al*., 2015).Without better understanding of the context and conditions in which they work, it will be difficult to support CHWs in improving their performance, and expecting them to provide their best service (Lewin, 2010; Glenton *et al*., 2013).

As noted in a 2009 policy statement by the American Public Health Association, CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison, link, or an intermediary between health/social services and the community, to facilitate access to services and improve the quality and cultural competence of service delivery (Pérez-Escamilla, 2010; Brownstein *et al*., 2011). CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counselling, social support, and advocacy (Pérez-

Escamilla, 2010; Brownstein *et al*., 2011). The following story of one CHW shares insight on the valuable work that they do.

Providing Service: A CHW's Story

The story of Ines is uplifting, and many CHWs have a similar story of providing service. A young woman, Ines, who fled Sudan for Egypt at the age of 23 with her husband, knew she wanted to connect people to each other and supply them with up-to-date information on a range of health issues (IOM, 2011). Both those activities were important to her because she had spent a long time feeling isolated after migrating to a new country, and did not know where or how to access services she needed herself. She trained on a health and psychology course for nine months, and once certificated in social work, she began her work as a CHW in the Sudanese community (IOM, 2011). Her work involved organizing advocacy campaigns to promote health awareness among Sudanese women, giving training sessions to groups of five to 10 women at a time, changing the mindsets of migrants towards NGOs and international agencies, and urging them to be more pro-active in safeguarding their health. She also educated them on issues like the flu, hygiene, basic health, and tuberculosis (IOM, 2011). It has been documented repeatedly that CHWs add value to the migrant communities in which they work.

A study, exploring the impact and feasibility of a pilot CHW intervention to improve diabetes management among Bangladeshi-American individuals with type 2 diabetes living in New York City, confirms the above point (Islam, 2013). An evaluation of the program reveals a high acceptability of the intervention, and importantly, qualitative findings indicate that CHWs helped overcome barriers and facilitated program outcomes through communal concordance, trust, and

leadership (Pérez-Escamilla, 2010; Barwise, 2013; Islam, 2013). In these studies, migrants reported being comfortable sharing their lives with CHWs, and with CHWs providing them with essential information and connecting them to the larger healthcare system in place.

CHWs' roles and activities are different from, and yet complementary to, those of other members of healthcare teams (Anthony *et al*. 2009; Oliver *et al*., 2015). They offer nonclinical knowledge and skills based on life experience shared with patients, which has been described as "experience-based expertise" (Gilkey *et al*., 2011). This shared experience is highly relevant to the challenges in dealing with the health system that are faced by many patients, particularly migrants, and equally those who are underprivileged and may have limited formal education (Pérez-Escamilla, 2010; Brownstein, 2011).

Whilst there has been a dramatic increase in global attention to and action on CHWs, particularly in relation to facilitating access to HIV testing and treatment in Africa (Barnighausen, 2007), it is not sufficient. Based on 2014 statistics, South Africa requires at least three times its current health workforce in order to provide adequate care for patients with HIV/AIDS (Ibid). The recent interest in training more CHWs, alongside developing front-line worker-based programs to control tuberculosis and HIV infection, is a respectable step in the right direction (PALSA Plus, WHO, 2017). It is important to monitor, evaluate, and study the impact this makes. This scoping review and literature search, however, did not encounter many citations on CHWs and their roles in providing migrants access to healthcare: only six of the 104 included citations had any mention of CHWs. Further research is therefore suggested, as CHWs play a significant role in

bridging the gap between communities and healthcare providers/services. More in-depth studies are recommended to further explore those knowledge gaps.

3.10 SUMMARY AND CONCLUSIONS

This chapter describes available evidence on health and access to care for migrants internationally and in South Africa. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers, researchers and policy makers, and reduced ambiguities in healthcare rights and obligations for undocumented migrants (Woodward, 2013).

Each article cited in this paper has emphasized the fact that access to health services can be either potential or realized. While many international treaties and national Constitutions have declared that all individuals have an equal right to potential access to care, realized access - actually using the services - is limited. The International Covenant on Economic, Social and Cultural Rights, known as ICESCR, recognizes that many countries face resource constraints at different levels, and hence discusses how the realization of the right to health can be a progressive process (International Covenant on Rights, 1976). Access should perhaps therefore be needs-based, but possible for all (Dobrzycka, 2008). However, several barriers limit access to health services for migrants. Some include ethnicity, age, poverty, education, language skills, legal status, area of residence, isolation, access to transportation, and culturally competent service providers (Dobrzycka, 2008; Barwise, 2013).

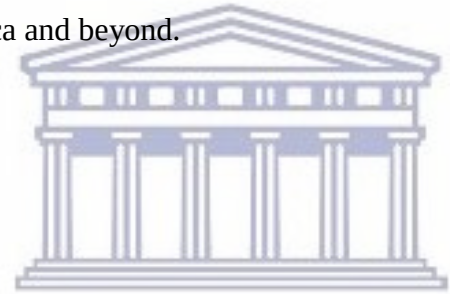
Aside from articles which explain the extent of the migrant health access issue, this review has identified a growing body of literature which documents how improvements are being made to facilitate access for migrants through various initiatives. It also includes recommendations which can lead to improved access.

International migration has moved to the centre of international and national political agendas in the last decade. For EU member states, international migration itself has become a common reality, although the characteristics around patterns of migration differ in terms of migrant origin, quantity, intensity, qualifications, and status, among other factors (Portugal *et al*., 2007). The values and principles of most countries in the world dictate that all human beings should fully enjoy a good a state of health. While it is important to recognize that the planning and adoption of policies to deal with the mobility of people and their health are a priority, the adoption of these policies is not straightforward (Portugal *et al*., 2007; Chimienti, 2009). The arrival of newcomers with different cultures and practices implies a two-way street in terms of integration and adaptation into the health system. Host societies need to adapt to new populations entering their system, and migrants need to adapt to a new environment and become familiar with the practices and cultures of the receiving societies (Portugal *et al*., 2007; Pérez-Escamilla, 2010; Barwise, 2013).

The current political climate is such that in many parts of the world, support is growing for political parties who promote anti-immigrant agendas, and governments in all countries are pursuing austerity policies. Given this setting, there is a greater need than ever for the public

health community to ensure that migrants have access to services that are effective and responsive to their needs (Mladovsky *et al*., 2012).

The health of migrants cannot be kept isolated from the health of the general population. Migrants are affected by the lack of access to essential healthcare services, including primary care, immunizations, pre-natal care, and routine health screenings (Carrion, 2012). Not only does this situation endanger their health, but it also puts the health of the larger public at risk. Hence, access to services for migrants should not be excluded from the policies of any country, and successful implementation of those policies, translating to better access, should be prioritized by all governments, in South Africa and beyond.



CHAPTER 4:

MIGRANT ACCESS TO HEALTHCARE IN SOUTH AFRICA - POLICIES, GUIDELINES, AND IMPLEMENTATION

4.0 INTRODUCTION

This chapter presents the findings of the scoping review and updated literature search to document existing health sector policies and guidelines from South Africa, on the topic of access to health services for migrant populations and continuity of care for that population. The methods used for the scoping review, as well as findings from the international literature, including good practice, were presented in Chapter 3, together with literature about migrant access to healthcare in South Africa. This chapter focuses on the South African health system as well as legislation and regulations particularly relevant to the study. These two chapters

combined respond to Objective 1 of the study, **"**To document existing health sector policies/mechanisms to support access to and continuity of care for mobile populations in South Africa, in relation to international good practice". This chapter and thesis has been written from a public health perspective, while engaging with the literature on migration.

The articles retrieved through this review show that migrants in South Africa (and all over the world) are still facing difficulty in accessing adequate and quality health services in their host countries. This chapter documents the policy and legislative context within which both migrants and the health system function in South Africa.

The primary purpose of conducting this review was to understand what policies, guidelines and practices are in place to address the issue of migrants and their access to health services in South Africa. Before this could be done, it was important to establish whether this is an issue which demands public health attention. This review and study as a whole have indicated that this issue does indeed require focus. Policies are governmental responses to the interaction of social, economic, political and cultural factors within a problem area (Antonipillai, 2015). While evidence has suggested that migrants experience inequalities in health and in access to healthcare services, there has been minimal analysis of the policies created to address migrants' concerns and mitigate the inequalities they continue to face (Mladovsky, 2009).This challenge, identified nearly a decade ago, remains relevant in 2017.

Migration has long been recognized as an important determinant of global health, with major influences on social development (Carballo *et al*., 1998). People are moving in greater numbers and over larger distances than ever before (Lurie & Williams, 2014). This trend has important implications for those who migrate and those who are left behind, as communities that host migrants have a responsibility for their well-being. Migration has deep historical roots in South Africa and continues to be a major factor shaping South African society and health.

In past decades, studies of migration and health in South Africa focused on migration as a vehicle for spreading disease (Lurie & Williams, 2014), primarily looking at how migrants were at increased risk for contracting TB and HIV at their place of work and home (Ibid). It also showed that their return to rural areas exposed their families and partners to diseases contracted on the mines, or other workplaces. Since then, HIV prevention has received increased attention, and today the county has the world's largest antiretroviral therapy program (Mayosi *et al*., 2012). Advances have also been made with TB in implementation of new diagnostics, treatment scale-up, and integration (Ibid). In the current decade, the research on migration and health in South Africa has shifted focus slightly, by recognizing that the combination of high rates of population mobility and growing rates of chronic disease pose important challenges for continuity of care within the population as a whole.

South Africa is in the midst of an epidemiological transition, as there has been a change in patterns of diseases and health over the past few decades (Lurie & Williams, 2014). It faces simultaneous epidemics of infectious and chronic diseases, which require long-term chronic care

(Ibid). With a growing mobile population being impacted by health conditions such as HIV and AIDS, planning for the continuity of their care in the context of chronic diseases should be considered by the health system. For example, people with HIV/AIDS need to take antiretroviral drugs daily and this should continue over a patient's lifetime. Similarly, obesity, diabetes and other chronic infections have become common, and also require lifelong treatment (Ibid). Of the ten countries with the highest rates of diabetes, seven are developing countries (Diabetes Atlas, 2009), while the death rates from diabetes are four times higher in sub-Saharan Africa than the world average (Ibid). Thus, in a context of high internal and international mobility, general health research – not only specialized migration and health research – should take mobility into account.

Migration is steadily on the rise, and the health of migrants can no longer be ignored if the health of the local populations is to be protected. Although many migrants are healthy, those who do need healthcare often face barriers in accessing care, and the care they receive may be inappropriate to their needs (Mladovsky *et al*., 2012). Governments should ensure that migrants are able to access health services in practice and not only in policy, as well as ensuring that the services are appropriate to migrants' needs, and that data systems are in place to monitor utilization and detect inequities (Ibid). Health services should adopt a 'whole organization approach', in which cultural competence is viewed as much a task for organizations as for individuals. Thus, health workers should take steps to overcome language, social and cultural barriers to healthcare (Ibid).

It is important to move beyond a framework of ethnic differences and inequalities in health, and to consider a range of factors that may explain the experiences and needs of migrants, including those who are most vulnerable and are restricted in their entitlement to free health care (Jayaweera, 2010). Despite the large body of literature touching on migrants and their healthcare access, the changing size, diversity and needs of migrants have yet to be sufficiently addressed in academic research and mainstream health policy and practice (Ibid).

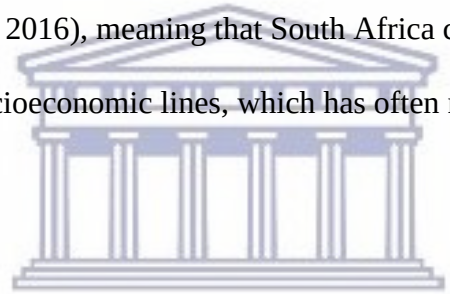
4.1 BRIEF OVERVIEW OF THE SOUTH AFRICAN HEALTH SYSTEM

Although the apartheid regime in South Africa ended in 1994, many issues which were developed and exacerbated within the health system during that time still exist (Coovadia *et al*., 2009). Issues such as racial and gender discrimination, large income inequalities, extreme violence, and the migrant labour system have all negatively influenced South Africa's past, and their effects on the health system can still be felt (Ibid). Along with this, failures in leadership and stewardship, and weak management have led to shortfalls in implementation of what are otherwise important and relevant policies (Coovadia *et al*., 2009). Thus, there is a need to strengthen effective and accountable leadership and access to services.

South Africa's health system consists of a large public sector, a fast-growing private sector, and a robust NGO sector. The public health services are divided into primary, secondary and tertiary divisions, through health facilities that are located in and managed by the provincial Departments of Health, and funded by the state (Jobson, 2015; Mahlathi & Dlamini, 2015). This sector has approximately 40% to 50% of all its expenditure on health coming from the National Treasury (Jobson, 2015; Mahlathi & Dlamini, 2015; HFP, 2016). The provincial departments are the direct

employers of the health workforce, while the National Ministry of Health is responsible for policy development and coordination (HFP, 2016). The majority of patients attempt to access health services through the public-sector district health system, which focuses on a primary healthcare approach.

Most health services in South Africa (about 86%) are provided through the public sector, but only about 50% of health expenditure comes from the government while the remaining 50% is paid for by private sources and a small percentage through donors (HFP, 2016). The private sector serves only about 14% of the population (Naidoo, 2012), and tends to cater to people with medium to high incomes (HFP, 2016), meaning that South Africa continues to have a two-tiered health system divided along socioeconomic lines, which has often resulted in inequitable access to healthcare (Ibid).



Health spending accounts for approximately 8% to 11% of GDP, allocated mostly to the nine provincial departments of health (Organization for Economic Co-operation and Development - OECD, 2014; Jobson, 2015). In her paper about the South African health system for Khulumani Support Group, Jobson (2015:3) notes that "while this is higher than the 5% of GDP recommended by the World Health Organization, it is reflective of the major burden of disease management and treatment, especially for HIV and TB, carried by the public sector in South Africa". However, this investment is still less than the 15% of budget allocations for health that African governments agreed to in 2001 in the Abuja Declaration (WHO, 2001).

The country's population distribution indicates that about 64.7% inhabit the provinces that are largely rural in nature (Mahlathi & Dlamini, 2015). Some of these provinces contain large cities, though the bulk of the population lives in rural communities (Ibid), where distance to health facilities requires longer travel times, making it less accessible.

4.2 INTRODUCTION TO LEGISLATION, POLICIES AND GOVERNANCE

Health policies are defined as the "formal, written documents, rules and guidelines that present policy-makers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health" (Gilson, 2012:28). However, these formal documents are translated through the decision-making of individuals such as health workers, patients, and managers - all policy actors who give meaning to written documents through service delivery, management, and their interactions with others (Gilson, 2012). Hence, health policies are often experienced very differently from the intentions of the formal documents, as the impact depends on the people who implement them (Lipksy, 1980). Therefore, policy can be seen not only as the formal statements of intent but just as importantly, as the informal, unwritten practices which policy implementers are responsible for (Buse, Mays & Walk, 2005).

Green Papers and White Papers are often the first step in the policy-creating process. They are government publications that outline specific issues, and then list possible steps to address these in terms of policy and legislation (The Guardian, 2009). A White Paper is a government's statement of policy, and it cites proposals for legislative changes or the introduction of new laws. Proposals often emerge from a Green Paper process, and culminate in a White Paper (Legislative Process - PMG, 2017). In South Africa, Green Papers are preliminary discussion documents,

while White Papers are broad statements of government policy, generally published before a bill as official legislation and are tabled in parliament (Ibid).

The development and implementation of relevant policy and supporting legislation require strong governance. Governance provides the framework by which implementing parties define their interests, rights and responsibilities, and decision-making and dispute-resolution processes in collective decision-making (https://iog.ca/what-is-governance/).Good governance has eight major characteristics (UNESCAP, 2007), among which are transparency, responsiveness, effectiveness and efficiency, and equitability and inclusivity (Ibid). Inadequate governance, or the absence of clearly-defined processes, roles and responsibilities for decision-making, is often at the root of many problems (Gilson, 2012). This also negatively impacts successful implementation of key policies.

This following section will present current key documents, policies and guidelines which were created to support migrant access to healthcare in South Africa. It will include South African constitutional, national, and provincial (Western Cape) policies and regulations. The section will also include two important government documents which do not give adequate attention to migrant health, although migrants are a profound part of their population. One has been created for and by the Western Cape Province (where De Doorns is situated) and the other by the City of Cape Town (140km from De Doorns, and an important influence). Current debates in South Africa are framed by a limited number of legislative and policy documents, which are presented below.

4.3 MIGRANT RIGHTS AND ACCESS TO HEALTHCARE: KEY DOCUMENTS AND POLICIES

The documents are presented in chronological order, allowing for a sequential understanding of how each document followed the next.

- South African Constitution (Act 108 of 1996)
- The Refugee Act (Act 130 of 1998)
- National Department of Health Memo (2006)
- National Department of Health Directive (September 2007)
- Gauteng Department of Health (DOH) Letter (April 2008)
- Vulnerable Groups Policy (2013)
- HIV and AIDS and STI Strategic Plan (2007 – 2011 and 2012 – 2016 NSP)
- White Paper on International Migration (2017)
- Western Cape Provincial Strategic Plan (2014 - 2019)

a. South African Constitution (1998)

The South African Bill of Rights (1998) and Refugee Act (1998) guarantee healthcare access to migrants for medical treatment, including non-emergency needs for refugees and asylum seekers. Article 27 of the South African Constitution on *Healthcare, food, water and social security* includes the following:

1. Everyone has the right to have access to:
a. Health care services, including reproductive health care
b. Sufficient food and water
c. Social security, including if they are unable to support themselves and their dependants, and appropriate social assistance.

2. The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

3. No one may be refused emergency medical treatment.

(Article 27 - South African Constitution, 1996)

b. The Refugee Act (1998)

South Africa has an integrative asylum policy, where no refugee camps exist and individuals are encouraged to self-settle and integrate within the host population (Matzopoulos, 2009). In theory, rights, which include the right to work, the right to an education, and access to public healthcare, are extended to refugees, asylum seekers, and international migrants (Ibid). In practice, however, access to these rights has long been problematic, despite the South African Constitution and the Refugee Act guaranteeing access to healthcare for all. The Act outlines "certain obligations to receive and treat in its territory refugees in accordance with the standards and principles established in international law" (Government Gazatte, 1998:2).

Inadequate mental healthcare has also been an important contributor to the rising global burden of disease for all populations, including migrants (Siriwardhana *et al*., 2013). There exists a treatment gap in resource-poor settings, especially when providing care for migrant populations. If care is at all available, it is primary care, and integration of mental health into primary care is a difficult task (Ibid). Thus, mental healthcare is often not accessible for migrant populations.

c. National Department of Health Memo (2006)

The top burdens of disease and death in South Africa currently are HIV/AIDS and TB, non-communicable diseases, injuries, and other Type One conditions (MRC, 2016). Cardiovascular disease was the leading cause of death prior to 1999, but HIV/AIDS and TB have dominated since. Migrants are as affected as locals by the heavy burden of disease in South Africa, and accessing treatments for them is as urgent (MRC, 2016). The National Department of Health (NDOH) Memo (2006) outlines that no patient should be denied Anti-Retroviral Therapy (ART) once that patient has been diagnosed with HIV. Each patient who comes in for health services in this regard must be addressed, without discrimination. The memo is one of several documents where the government has recognized that migrants are not being given the same treatment as South Africans with legal status. To quote from the memo, it "clarifies that possession of a South African identity booklet is not a prerequisite for eligibility for ART" (NDoH Memo, 2006). It further emphasizes that this access is equally essential for all populations, local and migrants and "patients should not be denied ART because they do not have an (South African) ID" (NDOH Memo, 2006). The memo is included in Appendix 3.

d. National Department of Health Directive (September 2007)

In September of 2007, the NDOH released a Revenue Directive (Matzopoulos, 2009) clarifying that refugees and asylum seekers shall be exempt from paying for ART services. However, research conducted by the Forced Migration Studies Program (FMSP) in Johannesburg indicated that migrants in need of ART reported challenges in accessing ART within the public sector,

commonly because they were not in possession of a bar-coded South African identity booklet (Matzopoulos, 2009).

e. White Paper on National Health Insurance (NHI)

The White Paper on National Health Insurance (NHI) was released in 2015-2016, after a significant delay (Vawda, 2015). Because it is a White Paper, the expectation was for it to provide clear conclusions on a policy in a way which allowed for implementation, and the development of any required legislation (Ibid). However, the NHI document has left many questions unanswered (Ibid). While the urgency of major changes to existing legislation was stated in the White Paper, there was little guidance on exactly what process would be used for any actual changes to be made.

f. Gauteng Department of Health (DOH) Letter (April 2008)

This memorandum, dated April 4, 2008, provided further confirmation that legal status is not mandatory in order to receive ART treatment, and was directed at hospital CEOs, District Managers and District Family Physicians. It also mentioned the importance of not denying any patient comprehensive HIV care and management, stating that it was not acceptable for any provider to be engaging in denial of services. It brought to light again that migrants are being unlawfully denied treatment, despite what the Constitution and other prior documents have stated. The memo has been included in Appendix 3.

g. City of Cape Town Vulnerable Groups Policy (2013)

This City of Cape Town Policy document defines vulnerable groups as “women, persons with disabilities, orphans and older persons” (VGP, 2013:5). The policy explains that these groups are

considered vulnerable as they tend to be marginalized and socially excluded, facing higher rates of abuse. They also tend to be poorer than other parts of the population, and this coincides with them being discriminated against more often. While these points are not being debated, the term *migrant* is not found anywhere in this document, and neither is access to health services.

Labor migration is mentioned twice - once in the context of families deteriorating because parents move away for work, and the other mentioning that older people in the household are being forced to take on more responsibility due to poverty, HIV/AIDS and the younger members in the household moving away for economic reasons (VGP, 2013). It is not referenced in the context of accessing health services.

Future documents addressing vulnerable populations in Cape Town may need to acknowledge migrants and their needs, both within and across South African borders.

h. HIV and AIDS and STI Strategic Plan (2007 – 2011 and 2012 – 2016 NSP)

The National Strategic Plans (NSP) outline how the country will respond to the prevention and treatment of HIV and AIDS, TB and STIs over five-year periods. Each NSP seeks to improve on the achievements of the last Plan (The National Strategic Plan 2012 - 2016, South African National AIDS Council - SANAC, 2013).

The 2007 – 2011 HIV and AIDS and STI Strategic Plan stated that non-citizen groups would be included, outlining their right to HIV prevention, treatment and support. As per the Refugees Act, policies were put in place which assured the right to health for refugees, asylum seekers and

cross-border migrants, including ART treatment (Government Gazette, 1998). NSP 2007 – 2011 massively scaled up the ART program and sought to decrease the number of new HIV infections.

The Progress Report on the NSP 2012 – 2016 is the country's third plan. It outlines a long-term plan for the country, and subscribes to the universal vision of the United Nations' Agency for HIV/AIDS (UNAIDS). Driving this vision are five goals:

> Goal 1: Reducing new HIV infections by at least 50%, using combination prevention approaches.
>
> Goal 2: Initiating at least 80% of eligible patients on antiretroviral treatment, with 70% alive and on treatment five years after initiation.
>
> Goal 3: Reducing the number of new TB infections and deaths from TB by 50%.
>
> Goal 4: Ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP.
>
> Goal 5: Reducing self-reported stigma related to HIV and TB by at least 50%.
>
> (Government of South Africa, 2014:14 - 17)

The Progress Report presents the following results:

- Considerable progress has been made in reducing HIV transmission during pregnancy and child birth, and perinatal transmission is estimated to be 2.7%. The country is on track to reach the NSP target of less than 2% perinatal transmission by 2016.

- In 2013, ART reached 2.5 million South Africans, including more than 200 000 patients being treated in the private sector. The provincial health departments will however need to enroll approximately 500 000 people onto treatment over the next four years to reach the NSP targets for ART coverage.
- It is likely that there is a decline in TB incidence and mortality due to the scale-up of antiretroviral treatment, though the WHO reports an increase in incidence and high mortality for TB. The country is not on track to achieve the ambitious targets of reducing both incidence and mortality by 50%.
- In relation to rights, some vulnerable key populations, such as sex workers, men who have sex with me (known as MSM) and prison inmates, are being focused on. Work is also underway to create access to legal services for persons discriminated against because of their HIV status, and work towards addressing gender-based violence (GBV) is in progress.
- While surveys show low levels of stigmatizing attitudes, the extent of stigma and discrimination from the point of view of people living with HIV (PLHIV) is yet to be determined. The implementation of the SANAC-commissioned National Stigma Index Survey will provide necessary insights, and also contribute to the development of appropriate indicators to track progress.

(Progress Report on the National Strategic Plan 2012 - 2016, 2014:21 - 22)

The Plan recognizes migrants, internal and cross-border, as a key population. However, as highlighted by Vearey (2014), no framework or guideline has been set on how to implement responses to HIV and migration.

i. White Paper on International Migration (2017)

The current policy on international migration was documented in the 1999 White Paper on International Migration, and is implemented through the Immigration Act (Act No. 13 of 2002), and partly through the Refugees Act (Act No. 130 of 1998) (Department of Home Affairs: White Paper, 2017). The new White Paper identified that much has changed since 1999, and that the 1999 White Paper is no longer relevant (Ibid). This 2017 White Paper recommends policy and strategic interventions in eight policy areas (Ibid). While none of the eight focuses exclusively on access to health services for migrants, one of them mentions providing "refugee protection and basic services to asylum seekers and refugees in a humane and secure manner" (Department of Home Affairs: White Paper, 2017:64), and health is generally considered a basic service. The Paper also states that, "Information on government services such as social assistance, safety, health and education" (Department of Home Affairs, 2017: 64) will be available to all. This mention of health-related information sharing is important. However, a dedicated focus on access to health is missing.

j. Western Cape Provincial Strategic Plan (2014 – 2019)

The intention of the Provincial Strategic Plan: 2014-2019 is to document the Western Cape Government's vision and strategic priorities for the current political party's (Democratic Alliance) second term in office. This detailed Plan presents five strategic goals, of which Strategic Goal 3 is *Increase Wellness, Safety and Tackle Social Ills*. This Goal starts off by explaining that the creation of "healthy, inclusive, safe and socially connected communities remains one of their most important goals" (PSP 2014 – 2019:33). The Strategic Plan acknowledges that when citizens are not healthy and safe, their potential cannot be maximized.

While in-migration is discussed several times, in the context of the "growing rate of urbanization and in-migration into the Province over the past 15 years" (PSP 2014 – 2019:43), there is no mention of cross-border migrants in this entire document, including under Goal 3. The PSP states that, "the Western Cape Government is committed to improving access and coverage of strengthened social services and providing a safety net for the most vulnerable and marginalized segments of society – including the poor, disabled, youth-at-risk, abused, and the orphaned, amongst others" (PSP 2014 – 2014:35). However, its mention of caring for its *citizens* allows for minimal room to consider that cross-border migrants may possibly be included under the 'amongst others' consideration. It therefore seems that the wording of Goal 5 is intended to cover only South African citizens.

4.4 RECOGNIZING CHALLENGES IN ACCESSING ART AND PMTCT

Under the South African Constitution, individuals without legal status are accorded the rights to access to emergency and basic healthcare, ART and Prevention of Mother-To-Child Transmission (PMTCT) services (Amon & Todrys, 2009). Asylum seekers and refugees are accorded free care, and they are meant to receive treatment which is no different from that allotted to South African citizens (Ibid). The Department of Health has issued memoranda clarifying that these rights apply equally whether the patient has documentation or not. Furthermore, the Western Cape government states that in order for a PMTCT program to be effective, mothers and their babies must:

- Receive antenatal services and HIV testing during pregnancy;
- Have access to antiretroviral treatment (ART);
- Practice safe childbirth practices and appropriate infant feeding; and

- Make use of infant HIV testing and other post-natal healthcare services.

(PMTCT - Western Cape Government, 2017)

The points listed above must be equally accessible to migrants and local populations.

4.5 RECOMMENDATIONS

While it is not the norm for the State to consciously make the effort to deny migrants access to healthcare, especially in public hospitals, access is not being ensured to migrants, as documented in the literature discussed in Chapter 3. Scholars such as Pophiwa (2009) have argued that there is a need to further explore factors impeding access to the healthcare to which migrants are entitled (Pophiwa, 2009). Kruger (2015) has shown that in De Doorns, Western Cape, there is a high rate of health service utilization, among both locals and migrants, regardless of gender, nationality or education levels. However, the reality of the South African public healthcare system appears to show a large variability in the services provided from one facility to another, and most migrants are not getting the access they need (Human Rights Watch, 2008; Kruger, 2015).

There is need for a broader policy debate on healthcare access for migrants in South Africa. A number of key issues have emerged from research, but have not been adequately addressed in policy or policy dialogue. Munyewende *et al*.'s article (2011) posed a number of recommendations to consider and prioritize:

a. Focus on policy-makers to simplify and/or remove ambiguous documentation systems;
b. Include migrant groups in HIV prevention programs;
c. Educate health workers about migrant patients' rights;

d. Provide information about the context of migration and understand the reasons why people leave;
e. Understand the experiences which migrants have in South Africa and the challenges they face in seeking health care;
f. Encourage health workers to adopt attitudes that enhance health service access and educate the public, migrants and citizens alike;
g. Conversations should include learning how to overcome misconceptions about HIV and its prevention, and seek support from funders to enable further research and support to address the gaps and needs of this vulnerable population group.

(Munyewende *et al*., 2011:159)

Each of the recommendations above is valuable in understanding the barriers migrants face, and in improving care for them.

4.6 CONCLUSION

South Africa's health system, Constitution and policies emphasize human rights and the righting of historical wrongs and inequities. This chapter and the literature reviewed in the previous chapter highlight both positive and negative aspects of the health system and the legislative and policy environment, in both theory and practice.

The health of migrants cannot be kept isolated from the health of the general population, and respecting the human rights of vulnerable populations such as migrants is an important contribution to building a cohesive and healthy society. As argued in the conclusion of the previous chapter, access to services for migrants should not be ignored in the policies of any country; successful implementation of those policies, translating to better access, should be prioritized by all governments, in South Africa and beyond. Accessibility is a broad concept, and

many kinds of research are necessary to investigate the accessibility of healthcare for migrants. Thus, it is important to know whether migrants are adequately informed about illness and the healthcare system (Ingleby, 2009). Along with this, health authorities need to know what information is needed, and in which languages, based on the populations they are serving, so that care is effectively presented. It is also important to understand how migrants' values concerning health may be different from those of service providers (Ibid). Furthermore, research is needed to uncover xenophobia, and direct and indirect causes of discrimination towards migrants within the healthcare system. Appropriate treatments and continuity of care for migrants should also be prioritized.

This review has described existing legislation and policy, and available evidence on health and access to care for migrants in South Africa. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers, researchers and policy makers, and reduced ambiguities in healthcare rights and obligations for undocumented migrants (Woodward, 2013).

However, it is not only the problems which need further research, but the solutions proposed for them too (Ingleby, 2009). Research is needed to evaluate the effectiveness and impact of the 'good practices' and policies which have been put forward, or are proposed to be set in place (Ibid). As many articles have documented, there is a shortage of studies on the effectiveness of policies and practices put in place to mitigate migrant healthcare accessibility issues. The gap is so large that there is doubt that any of the current policies and 'best practices' used today are truly evidence-based, and this is concerning (Ibid).

CHAPTER 5:

HEALTH SYSTEMS ISSUES AFFECTING ACCESS TO CARE

5.0 CONSOLIDATED SUMMARY OF KRUGER'S FINDINGS

As shared earlier, James Kruger's quantitative study was one of the most substantial bases for this qualitative one. Kruger's research confirmed that the patterns of migration, employment and residence in this area are complex and changing (Kruger, 2015). He found that the migrant farm worker population in De Doorns is mixed, with half of their study sample being South African. While a large proportion of these respondents also traveled to other areas for work, one third of Kruger's respondents thought of De Doorns as their permanent home (Ibid). A significant percentage reported permanent work in the area, although the large majority was still casual workers with unstable employment (Ibid).

Kruger's study showed that a large majority of both foreign and South African migrants did use the clinic for a range of both acute and chronic conditions, with variations by gender, presence of children in the household, nationality, education and neighbourhood of residence (Ibid). This suggests that despite structural barriers to access particularly for foreigners, which this qualitative study has explored and documented below, South Africa's constitutional protection of access to primary healthcare for all people living in the country is being implemented in De Doorns (Ibid). However, levels of satisfaction with the quality of care received and with waiting times are fairly low, and they are worse for referral systems (Ibid).

Kruger's study has confirmed that the residents of De Doorms do want health and childcare services to be provided closer to their residence or place of work (Ibid). His work cites the need for in-depth (qualitative) research to more fully understand this community's needs.

5.1 INTRODUCTION

This chapter will present respondents' perspectives on issues affecting access to healthcare services for the migrant population in De Doorns. This and subsequent chapters report issues discussed by migrants themselves, and also those identified by CHWs, De Doorns clinic staff, a Provincial manager, and a District manager. Some issues were discussed by more than one group of respondents as there were overlapping concerns, whilst others were of particular concern to some respondents and not others. In these empirical chapters, findings are presented in accordance with the themes identified through the analysis described in Chapter 2, and in relation to the study objectives and the conceptual framework. Where diverse or diverging

perspectives were expressed by different respondents or between different categories of respondents, these are indicated. Overall, the perspectives of migrants are the primary focus of this work.

The chapter begins with issues identified by migrants as affecting access to care. This will be followed by strategies migrants utilize to access care. The perspectives of other respondents – health workers, managers, community health workers – are interwoven throughout the chapter under the relevant themes.

5.2 STRATEGIES UTILIZED BY MIGRANTS TO ACCESS CARE

Accessing care is essential for the migrant population, as they are economic migrants and must remain healthy in order to work, and this is particularly the case in the farm labor context, where physical health cannot be compromised. This study has shown that migrants use a number of strategies to access care, given the barriers they face.

5.2.1 Navigating a New Territory

Researcher: Okay, do you think is important to ask where the clinic is, when moving to another place?

Yes it is important, because that the first thing you must ask when moving to another place. Also ask where the police station or hospital is.

Researcher: Why?

Because I will know where to go when am sick and I will know where to go when am robbed so that I can get help.

(Male, 33, Free State, Migrant, WS550069)

When asked if they knew where the local clinic was, all of the migrant participants responded positively, saying they made sure to ask about the location of the clinic as soon as they arrived. They also placed importance on knowing the location of the police station, as safety and violence in De Doorns have shown to be a widespread issue.

The participants also said they knew how to access the Worcester hospital, the closest hospital to De Doorns, particularly on evenings and weekends when the De Doorns clinic was closed.

> *Yes is important (to know where the facilities are) because sometimes will get sick during the night and must be able to know where the clinic is and when am sick during the night I call an ambulance to take to me the hospital in Worcester.*
>
> *(Female, 31, Lesotho, Migrant, WS550089)*

5.2.2 Navigating Identification and Discrimination

Two major strategies have been identified as useful in navigating access to services in a context of discrimination against foreign nationals. One such strategy is to share personal IDs. When one individual has an ID, they let others who do not have one borrow theirs. This has been said by clinic staff to cause issues for them and for the migrants themselves. As a result of this, migrants have been misdiagnosed as using the incorrect ID leads to incorrect files being used during their visit, unless the staff member attending to them has been able to figure out the discrepancy before administering treatment. Thus, it is not very effective as a strategy for accessing services.

> *We do sometimes have problem with them like when they come to the clinic without proper documents and they will use someone's file and that's where thereby we tell them that they will be caught. Like sometimes a person will come with someone else's file, that has different details and we will ask that person which one is his or her name or last name or ask whether he or she has been tested before and she or he will say no and the file will say the person has*

been tested before. We normally ask if you are on medication or not and that is when we find that it is not the patient's file...

(Female, Mphumelelo, Counsellor De Doorns Clinic, WS550108)

Another strategy used has been to access emergency care in a timely manner. Migrants have claimed that there is a much longer waiting time when they call for an ambulance in times of a medical emergency, compared to local residents placing the call. They explained that EMS staff on the receiving end are able to decipher the fact that they are not local by their accents, particularly if English is spoken, and as a result do not give priority to their calls. Some described giving birth at home because the ambulance did not arrive for hours.

Yes, they take hours especially when you call speaking English, they can tell you from far.

Researcher: What is that telling us? Is there difference in service between migrants and the local people?

Yes, it is because how can you say that when someone speak Afrikaans you here within 30 minutes and I speak English and the next one or two hours you not here? You can even deliver the baby in the house, because they are taking long.

(Migrant FDG, WS550100)

A strategy some migrants used to overcome this barrier is to have a local person call for them. Migrants have shared many instances of where this has gotten them the services they required in a timely manner. The following series of quotes illustrate their concerns on this issue.

You call the ambulance, but what I have seen so far is that if you are a foreigner and you call an ambulance it took time. But when a South African calls the ambulance they respond quickly.

Researcher: Why do you think? How do they know if you are and South African or not?

They will ask you the name and where the person who is sick comes from, and you will tell them. I have seen it when my aunt was pregnant and about to deliver I call them ambulance to come and take her to Worcester and they took long time to come until I went to my neighbor and when she calls them she asked them where are you because the person is about to deliver and that's when they came and it was about 4 to 5 hours since I called.

Researcher: The neighbor is Xhosa? Is she local?

Yes, and when she call the ambulance came, and it surprises me why when I called they took time and when she call it came.

(Female, 39, Zimbabwe, Migrant, WS550090)

These strategies show that migrants prioritize their health, and are willing to find ways to navigate barriers to accessing healthcare. These include asking their relatives and neighbors where the clinic is located, and once they visit the clinic and experience challenges, they have shown to be strategic about how to overcome them. Despite their efforts, it is more important for the health system to recognize, understand and minimize the barriers this population faces.

5.3 ISSUES IDENTIFIED BY MIGRANTS AS AFFECTING ACCESS TO CARE

Things that happen in De Doorns clinics are very sad. Before you get help in the clinic you have to make an appointment, and when you have made the appointment on Monday they will give you Wednesday or Thursday and by that time you are sick and your condition is getting worse waiting for the appointment. Two, you also have to stay for a long time at the clinic without working. Three the nurses are mostly coloureds that don't really explain to you what is really happening with your condition because of language barriers.

(Female, 34, Lesotho, Migrant, WS550099)

This section will present challenges which have been highlighted by migrants in the process of accessing health services. All sections in this chapter are interconnected and impact migrants' access to care in different ways, as the various components of a health system seldom function in isolation from each other. The issues emerging in this section are presented as themes around which ideas and concepts have clustered. Thus, when people spoke about waiting times, other themes impacted this. Similarly, when people spoke about appointments, it evoked wait times, staffing challenges, document requirements and xenophobia. The order in which each theme has been presented is guided by how strongly and frequently the participants mentioned it as a barrier, starting with their strongest concern. The themes emerging in relation to health system factors perceived by migrants to negatively affect access to care are: the appointment system, health system requirements for legal identification documents, language and confidentiality concerns, long waiting times, staffing and resource limitations, user fees and cost-based denial, missing patient files and misdiagnosis issues, clinic location and operating hours, discrimination and violence.

a. Appointment System

The appointment system in the Western Cape began in 2014, with the purpose of reducing waiting times and preparing for patients in an organized manner. It was meant to provide better management and better planning of resource usage in facilities (personal communication, James Kruger, Oct 31, 2017). Staff at the De Doorns clinic also confirmed that the appointment system was set up by the government for these reasons.

However, the findings of this research revealed dysfunctionality in the appointment system, and

understaffing at the clinic has added to the complexity of the situation. As there is not enough staff, it has been difficult for them to tend to patients at the time of their given appointments, causing long delays.

The appointment system implemented at the DeDoorns clinic has been stated (by migrants and CHWs) to be a significant deterrent to access for reasons beyond just long waiting times. Migrants report frustration over the fact that they are not attended to at the clinic without an appointment, regardless of what they say or how urgent they feel their needs are. The quote below highlights their sentiments, and notes that not all migrants possess legal documents. As a subsequent section will show, another challenge migrants have emphasized is not having access to services without first presenting legal papers to the clinic at the time of registration.

The quote simultaneously discusses sentiments, appointments, and legal documents. This conveys the sense that it is one challenge after another, and that an apparently simple system like appointments triggered quite a complex and problematic chain of actions, requirements, and reactions.

> *Because here when you are sick and you go on that day to the clinic, they will tell you that you must first make an appointment. And for a person from Lesotho sometimes one does not use border gate, but cross through the river and things like passports get lost and with appointment is risky as they give an appointment of let's say 23 and you get sick before that day.*
>
> *(Female, Lesotho, Migrant, WS550052)*

Both migrants and CHWs have also mentioned that the growing migrant population in De Doorns may possibly be one hindrance to the smooth implementation of the appointment system. While the quote below touches on both the appointment system and the large population, the

interviewer has focused on one of the two points for primary clarification.

> *Yes, it is not working at all (appointment system) and also is because there are too many people.*
>
> *Researcher: Can you use the service without an appointment or must you have an appointment?*
>
> *No, you can't see the doctor without an appointment. They will write an appointment for you if you don't have.*
>
> *(Female, 20, Laingsburg, Migrant, WS550093)*

Migrants have emphasized their frustration at the way the appointment system is implemented, as they only go the clinics when there is urgent need. They are therefore not keen on returning at a later date when they may either not need services any longer, or they may be in a worse condition:

> *...the challenge is that you cannot predict when you will get sick, sometimes it can happen at night and then you wake up and went to the clinic for help and you will be told to make an appointment where as you are very sick and need help. This is the problem we are facing in the clinic.*
>
> *(Female, 40, Zimbabwe, Migrant, WS550071)*

Some migrants explained that taking their sick children to the clinic also resulted in the denial of services, as they did not come in with an appointment. They had hoped to get a different response when babies and children were brought in, as infants and minors cannot also be expected to wait for hours.

> *Last time I went there when my child was sick and was a struggle because they told me to set an appointment with a sick child. I made a same day appointment and was in the morning, left around 2pm.*
>
> *(Female, 29, Lesotho, Migrant, WS550104)*

This increased their disappointment in the clinic and with the appointment system itself. They were further upset because they felt that the staff could see them not being well, and requiring immediate attention, and still sent them home to return at a later date and time.

> *They won't listen to you, it happened to me twice you have to go according to the appointment. Even if you were sick the whole night when you get there they will give you an appointment to come back on the date. And even when they can see that this person is very sick they still give you an appointment.*
>
> *(Female, 39, Zimbabwe, Migrant, WS550090)*

This issue overlaps with long waiting times also, as migrants explained that when they do come in for an appointment, they still wait the entire day to be attended to. They expressed confusion and frustration about why there is an appointment system if it is not being implemented in a proper manner. In their view, it serves no purpose and instead hinders access. CHWs have expressed similar concerns.

> *I am facing long wait times, as yesterday I had an appointment of 10am and got out of the clinic at 3pm and that is not right. I still don't understand why we have appointments and wait the whole day.*
>
> *(CHW FDG, WS55085-86-87)*

While a few migrants said that they have been told it may be possible to see the doctor without any appointment if the matter is urgent, they felt it still has not helped with the overall issue of accessibility because it involved long wait times.

> *Researcher: Can you go without an appointment to seek services?*
>
> *...there is a system they use for those who don't have appointments, but is not working as you take long.*
>
> *(Female, 39, Worcester, Migrant, WS550092)*

The interconnections between barriers to healthcare are visible in this point. Alongside migrants sharing their thoughts on the inefficiency of the appointment system, they also discussed the connection it had with their employment and financial situation. As the migrant participants of this study are agricultural laborers, and often employed only seasonally on the grape farms, most report getting paid only for the days they work. If they wait an entire working day at the clinic despite having an appointment, they lose that day's income. They have further explained that while some farms may accept a note from the clinic explaining the absence, other farms do not. This can and has resulted in them losing their job at that farm. Migrants repeatedly emphasized that this system is not working, and is deterring them from wanting to visit the clinic, as they cannot afford to risk their jobs. It puts them in a difficult place, because they also cannot continue working when they are not physically well, as farm work is labor intensive. CHWs have confirmed these concerns, and shared how it has made access difficult for the migrants they served.

Researcher: Is the appointment system a problem?

Yes, a lot.

Because people are coming in for the service today and they are being given an appointment to come back later and this is detouring a lot of people. People say they don't want to go if we need to get appointment again.

And also those who have appointment say you have 08h00 appointment, you will be helped at 11h00 to 12h00 and get out of the clinic at 13h00 and what about 09h00 and 10h00 people.

The appointment system does not work at all.

I think what is stressing the people also is they expect to be helped on their appointment time so that they can go home early.

Researcher: So there is long wait time with the appointment still?

Yes.

Researcher: There is no purpose to the appointment?

No purpose.

Researcher: Is there anything good about the appointment at all?

Nothing.

Like when you are late for your appointment, you will be told to wait outside maybe for two hours and wait for the others to go in first.

Researcher: How is this impacting the migrants who must work on the farms?

They also must wait.

Others lose their jobs because they have waited the whole day without receiving the treatment and that will mean no letter for the employer.

(CHW FDG, WS550097)

However, it is important to recognize varying viewpoints. While the CHW accounts largely agree with the migrant voices on this issue, the clinic staff shared a different perspective. The staff said they feel the appointment system has been working well, and other than the occasional technology challenge with their computer systems, they have not experienced issues.

Researcher: How well do you find the appointment system is working?

Is working very well. Unfortunately at the moment we got a problem with our front computer, but they write all down and if the patient had an appointment they will write down that the patient has an appointment and have his or her file ready to go through.

(Female, Mphumelelo, Counsellor De Doorns Clinic, WS550108)

Contrary to migrant accounts, clinic staff stated that all patients were attended to on the first day that they came in. The staff explained that a triage system was in place: after being seen by the nurse, patients were given an appointment to return at a later time only if their condition was not deemed urgent.

Researcher: So one thing I have been hearing from migrants at large from different countries is that if you don't have appointment, you won't get any help and they must go back home. Is this the case?

No, not here. When you get to the sister, she will determine whether you should be helped today, tomorrow or next week and that will be according to your sickness.

Researcher: Everybody goes to the sister and she will determine whether your need is today or another day?

Yes.

(Male, Counselor De Doorns Clinic, WS550109)

The staff was insistent that every patient is attended to, and given the care they require based on their condition. They assured that first time visits and those coming in after missed appointments were treated with the same importance as those with appointments.

Researcher: If I don't have an appointment, will I still get help?

That is why we have triage system. If you don't have an appointment, we take your card and you are helped by a sister who will also help those who missed their appointment. We don't send anybody back.

(Male, Counselor De Doorns Clinic, Migrant, WS550109)

The discrepancy in the accounts of the migrants and CHWs versus that of the clinic staff is interesting to note. Empirical observations over an extended period may help to clarify this, as routine records may not necessarily indicate whether a patient was seen on an appointment or as an emergency, nor how long they waited. An additional partial interpretation may be that, despite challenges the clinic staff may be facing internally, they did not want to disclose it in interviews, to protect the image of the clinic and to not further encourage a negative impression of the way the clinic was run.

b. Importance of Legal Documents in Accessing Care

Migrants report that the possession of legal documents - passports, affidavits from the police station and/or other versions of identification cards - has been an essential requirement for them in being able to access services. Unfortunately, many do not have documents to show. While some have come illegally and genuinely do not own documents required to live and work in South Africa, others report having lost them on their travels. The travel which many endure in getting to De Doorns is difficult, and participants explained that on that journey, many of their important belongings, including documents, were stolen or lost. Some migrants crossed rivers to illegally enter the country, and their belongings were ruined in the process. As the clinic staff requires identity documents before a file is opened for a patient, this has created a barrier to access for those without one. While certain government offices will create an affidavit to use as an ID for migrants who come to them, migrants do not feel encouraged to go apply for these due to fear of deportation.

Another associated issue shared by some was a fear of legally crossing the border into South Africa because their passports and/or South African entry and work permits were no longer valid. They would not be allowed to enter without this, and hence have found alternative, albeit dangerous, ways of entering the country. This further explains why many migrants do not have IDs.

There are no problems that I encounter besides the bridge.

Researcher: What happens at the bridge?

They require one to have a passport. If your passport is behind with a few days or a month; you are unable to pass at the bridge. Thus the only way to cross the bridge is through the river. It bothers me a lot. Some people drown while trying to cross the river.

We are afraid to go to the police at the bridge because we will get arrested.

(Female, Lesotho, Migrant, WS550047)

Along with migrants, CHWs and clinic staff, a manager at the Worcester hospital who was in a role of influencing care for the De Doorns migrant population was also interviewed. The manager has echoed some of the concerns mentioned above, adding that aside from legal documents allowing residence and work in South Africa, referral letters given out at the clinic for patients as they travel are also not always reaching "the other side" (Female, Manager, Worcester Hospital). As migrants travel, they lose the letters easily. They have only one letter, which gets taken in where they first stop for service. Hence, the Worcester manager explained that the letter may not make it to Zimbabwe, for example, if the migrant stops at a clinic in Pretoria. Related to this, the manager reported seeing a lot of migrant HIV patients defaulting, as they are on the road very frequently and their continuity of care has not been consistent, partly because the referral letters are not utilized.

c. Language Barriers, Patient Confidentiality and Respect

The role of language as a barrier to access is important to acknowledge, as migrants explained that they often could not access care due to language constraints. Those migrants who were able to understand enough to receive services highlighted numerous other barriers, described in this section.

Because not all migrants and staff are able to communicate in the same language, migrants experience hostility in the way the staff address them.

We don't get a good service; because of we don't have passport or ID. They tell you that

you must get asylum. They fight with us every time we go the clinic and swear at us. Because we don't speak their language, we end up getting no help.

(Migrant FDG, WS550098)

In order to get help you must first have an ID or passport and most people don't have ID or passport and they end up not getting help at the clinic.

(Migrant FDG, WS550098)

However, the staff at the De Doorns clinic confidently reiterated that they work to facilitate every patient, regardless of their country of origin.

For language we mostly ask the counselors to help us. So is something that we fix right there.

(Male, Staff at De Doorns Clinic, WS550109)

This discrepancy between the two views may be explained by noting that the De Doorns Clinic staff is limited in number, compared to the population they serve. The Head Nurse at the clinic explained that due to this short staffing, someone is not always available to assist with translation (Head Nurse, De Doorns Clinic).

This study included both internal and international migrants. While migrants from Zimbabwe often spoke English, migrants from other countries and from the Eastern Cape commonly did not, and the staff at the clinic spoke English and/or Afrikaans, which was not helpful to all the non-Zimbabwean migrants. Migrants expressed frustration because, even after the long hours of waiting, they cannot communicate the purpose of their visit to the care providers. Migrants reported that the staff asked them to bring translators along. While some did this when possible, other migrants said they are unhappy with this request, because either a translator is not always

available or they want to keep their health issues confidential from their neighbors, friends and relatives (who are the potential translators). Migrants were upset because they felt service provision has only been geared to those who speak the same languages as staff.

> *I wanted to say that I sometimes have problems at the clinic because I cannot speak Afrikaans or English, and because I don't have an ID. They sometimes ask people to bring translators for them to help you, if you do not have a translator they refuse to help you. It seems as if treatment is only given to those that are able to speak English and or Afrikaans. There are a lot of issues at the clinic.*
>
> *(Female, Lesotho, Migrant, WS550047)*

Migrants further explained being unhappy when their children also did not receive care due to the same language barriers. While they spoke about the staff having no interest in wanting to communicate when they came alone, they hoped that when they brought their children, more interest would be shown. However, migrants reported being sent home from the clinic instead of being served, and this issue has caused disappointment.

> *Especially on the side of young children, I once took my sister baby to the clinic because her mother was at work. I was then returned home with a sick child because I could not communicate or find someone to translate for me.*
>
> *(Migrant FDG, WS550098)*

Aside from the confidentiality concern, migrants also shared that it is not always possible to find and take a translator with them when they or their children require it.

> *My only problem is that as a migrant you don't know their language. They will ask you to get a translator and if can't get one, they won't help you.*
>
> *(Female, 31, Lesotho, Migrant, WS550105)*

CHWs agreed with this as a challenge, and also recognized it as a deterrent to migrants accessing care. CHWs reported that migrants leave the clinic when there is nobody to help them.

> *And you will find that patients don't get help at the end of the day, and go home if they couldn't find a translator for that patient.*
>
> *(CHW FDG, WS55085-86-87)*

Although CHWs agreed with migrants on the language issue, counselors at the clinic did not. They instead stated that although migrants do speak different languages than the staff, the staff worked to translate for migrants, and they therefore did not see it as a challenge.

> *The other thing is the language, when they cannot communicate with the sister and that's when we come in.*
>
> *(Female, Mphumelelo, Counselor De Doorns Clinic, WS550108)*

As a strategy to access care, some migrants who do speak English and/or Afrikaans spoke about having translated for others who do not. However, confidentiality issues were also been cited in this instance. While these migrants want to help others in receiving services, they realize not everyone wants to share their health conditions with people other than clinic staff. As mentioned earlier, those who have assisted with translations are often people from the community. In a community where HIV and TB are prevalent, migrants reported preferring privacy over disclosing health status. Thus, even at times when a volunteer from the community agreed to translate, migrants left the clinic untreated because they valued confidentiality over services.

> *They (staff) speak English, but that makes it easier for migrants from Zimbabwe and Nigeria. As for migrants from Lesotho and others, is difficult and that will require them to find a translator and some they scared as their sickness is confidential so they will end up leaving (the clinic).*
>
> *Researcher: So even if they find a person to translate confidential information, they don't want to share?*

Yes they don't want their information going public.

(Female, 35, Free State, CHW, WS550091)

Confidentiality breach issues were also cited with regards to staff behavior and actions. Migrants shared concern and frustration about staff making their health statuses public. One way staff did this is by displaying patients' names and condition on a public board when they missed an appointment. This upset migrants, and some have threatened to report those staff members to the clinic manager.

...They (staff) said if you don't come to the clinic they will place your name to a board and if you are at the clinic no one cares but when they place your name on the board everyone will see that you are sick and that is unnecessary.

Researcher: So they write your name on a board at the clinic?

Yes and they say if you don't come to your appointment they will place your name on a board just like I have AIDS …

Researcher: So do they do that here in De Doorns?

Yes and that is unnecessary because my sickness is not to be shared with a third person and…

Yes like the other day one of the nurses told other patients at the clinic about another patient sickness, and I told the lady that if it was me, I would report her to the clinic.

(Female, 31, Lesotho, Migrant, WS550089)

Accounts showed that migrants have faced numerous interconnected obstacles when attempting to access services. The following quote brings together language issues, discrimination, and long waits times, and it underlines the challenges which deter migrants from using the clinic.

If you went there at 7, I was there yesterday, but I don't know how it works, when you have a challenge, or do not understand Afrikaans. Even if you are inside they will make you go and look for your own translator outside, and then they will take you up and down. By the time you came back with a translator, you will have to queue from the back

again. It's like that, that it why I said there is too much racism in this place, and I do not think is something that will end soon. That is the reason that will make me not to come back in this place.

(Female, 24, Eastern Cape, Migrant, WS550079)

Along with CHWs agreeing with migrant on the challenges raised by language, they also highlighted waiting times, which was discussed earlier in this chapter.

Yes the language. We need translators at the clinics in order to make communication easier. And the waiting period is affecting their work.

(Female, 44, CHW, WS550063)

However, the issues at the De Doorns clinic may or may not be the same as at the Worcester hospital. Senior management at the Worcester hospital, which migrants in De Doorns used during evenings, weekends and in times of emergencies, have stated that everyone receives equal treatment at the hospital, and that the barriers at the clinic do not apply to them.

Worcester hospital doesn't ask where they come from, treats everyone the same and treats only on sickness/severity; problem is other provinces don't have level of care that this does - so they come very sick.

(Female, Hospital manager, WS550115-116)

While the migrants in this study did not share many negative experiences of the Worcester hospital, they also did not comment on what issues they faced during their visits. CHWs also did not share their thoughts on their own experiences, or those of migrants, in relation to the hospital.

d. Long Waiting Times

Long waiting times to access services at the De Doorns clinic were repeatedly cited by the migrants as a cause of frustration and a deterrent to using health services. While some waited for many hours, others claimed waiting an entire day, and some were not seen even after the full

day's wait. This echoes the findings, and the chief reported respondent complaint, of Kruger's study (Kruger, 2015).

Among respondents who were not seen but who required urgent care, some described turning to a pharmacy or a private provider outside of De Doorns, usually in the neighboring town of Worcester (34 km away) if they could afford it. However, others said they could not afford alternatives. Having to pay for services - a doctor's visit and possibly medication - puts migrants in a difficult position, as many work long hours for low pay, and since some also send remittances home.

> *Most of them go to the private doctor and pay R250 and go to the pharmacy but medication and that is too expensive for us, as we came here to work.*
>
> *(Migrant FDG, WS550100)*

Some migrants explained that they come on empty stomachs and stay the entire day without food, in hopes of accessing services. These reports of having to wait for the entire day have been heard from migrant participants throughout the study.

> *Is very true, because sometime we arrive early at 8am and leaves around 12 pm or 4pm and we leave our home without having to eat.*
>
> *(Migrant FDG, WS550098)*

CHWs in the study also confirmed long waiting times, based on their own experiences and those they have heard from migrants, as patients who have to wait for many hours on every visit do not feel motivated to go back to the clinic. Clinic staff agreed that the wait times are long, as they are understaffed to meet the needs of the growing population in De Doorns.

> *Yes they do and have waiting problem in all areas.*

Researcher: How do people deal with this?

It discourages the people.

(Female, 20, Laingsburg, CHW, WS550093)

Long wait times were also discussed in the context of discrimination and xenophobia, which is discussed in Section i below.

e. Staffing and Clinic Resource Limitations

Migrants, CHWs and staff all report that the population has grown dramatically in De Doorns, and continues to do so each year. According to staff at the clinic, a new migrant patient file is opened each day, and they describe being understaffed to meet this large (and growing) population, and overwhelmed as a result of the volume. Due to there being few people running the clinic, if one person is ill or not working fast enough, it slows down the entire facility. The staff reported migrants openly show their frustration with the long waiting times, but argue that what all patients (migrants and locals) do not understand is that there are many internal challenges facing the clinic staff. Alongside needing more trained staff, they have also spoken about wanting a larger facility to accommodate the growing population.

Definitely. Is a big problem (staffing). Say for example C window, I must see the patient, I must input the data onto the computer, and I must file and take out the file and for me to do that is too much. Somewhere something is lacking there and one of us gets sick or goes on vacation there is no replacement and the window is open. We have to take somebody to help even if you get someone to help something somewhere will lack also, so my problem is there is shortage of staff.

Researcher: So it is too much for you?

Yes, it is too much for everyone who works in this clinic. And the patients will take out their frustrations on us thinking we are slow but they don't understand the problem inside. Everyday a new person comes in, new babies, people from Oudtshoorn, migrants coming in, so the population become bigger and bigger and the staffs remain the same.

(Male, De Doorns, Clinic staff, WS550109)

Migrants in this study agreed that more staff and a larger facility are needed, as they report not being accommodated even following long waiting times on their appointment days.

> *The clinic is very small for the De Doorns population as is big. It will be better if they could make it bigger in order to accommodate everyone and also we don't have to miss our work waiting for the appointment day.*
>
> *(Migrant FDG, WS550100)*

CHWs echoed migrants' concerns regarding the clinic staff struggling to work efficiently with limited staff.

> *(They are) overworked. They must put more staff (in the clinic).*
>
> *(CHW FDG, WS55085-86-87)*

CHWs went on to describe how staff attitudes may be impacted by their demanding workplace, which in turn may serve as a negative experience for migrants attempting to access services.

> *The staffs at the clinic have moods and that scares the patients.*
>
> *(CHW FDG, WS55085-86-87)*

The quality of care an individual receives and the overall experience provided by the clinic staff have both been highlighted as having the potential to encourage and/or discourage migrants from using the clinic. Migrants shared personal accounts of poor service and being ill-treated, and CHWs confirmed these accounts. CHWs also articulated concern about how well the clinic staff does their jobs, and highlighted issues of incorrect or incomplete treatment.

> *They (clinic staff) don't do their work properly.*

And when you get to the clinic, they ask all sorts of questions, like what did you see and all that. Sometimes they will tell you that your child's TB is fine after six months of taking your child to the hospital, and say you must continue with the treatment and having a letter from the hospital.

(CHW FDG, WS55085-86-87)

Along with this, both CHWs and migrants brought up the possibility that the existing staff are not performing efficiently. While some perceived a need for more staff, others reported being upset with the long waiting times and felt that this may have been a result of the staff not working hard enough. Some migrants and CHWs expressed sympathy regarding the limited number of staff available at the clinic, while others had less sympathy.

The staffs (numbers) are okay. I don't know what their problem is.

The staffs is right, just that they are lazy.

They are very lazy.

Yes, they are because we spend too much time in the clinic and moving you from one place to the other until the end of the day.

(Migrant FDG, WS550088)

Also, as mentioned in an earlier section on long wait times, migrants repeatedly described being unhappy about the fact that even their babies and children have to face this same situation of delays. Delays touch on long waiting times, and migrants claim that an understaffed clinic impacts the waiting times negatively too. They explain that a combination of these issues act as a deterrent to access for them. Their words reflect a deep frustration with this situation.

There are no special attentions with the babies; you will still spend the whole day waiting for help.

Researcher: So with the baby there is no difference?

Yes, even you cry for help they won't help you.

(Migrant FDG, WS550088)

Another issue which was touched upon earlier was that of the long waiting times, despite having an appointment for a certain time. This made migrants question the purpose of the appointment system, resulting in some leaving the clinic feeling worse than when they came, due to an entire day of waiting for services. While being short-staffed is not the only factor creating such long wait times, migrants and CHWs feel it is a prominent contributor to this challenge.

My problem is a waiting period that we spend in the clinic waiting for assistance. They take time. Even when you had an appointment, you will wait the whole day and by the time you finish you will be not feeling well anymore as you arrived at 8am and finishes at 4pm.

(Migrant FDG, WS550088)

f. Cost-based Service Denial

In addition to the opportunity costs of foregone wages and potential dismissal due to missing time at work, some respondents reported that care has been denied to migrants due to direct costs of the South African health system. Migrants shared various accounts of effective denial of care because of inability to pay, where they were denied certain treatment or an operation was refused because it was expensive. Physicians told them that they will have to do it when they go back to their home countries. This has caused frustration for migrants, as they live and work in South Africa, and need to be healthy to continue working. It is unsettling for them to have to travel back to their countries for treatments, simply because they are not South African.

Since 2013 I had thyroid problem, was transferred to Worcester (hospital) for an

operation. When I get there after my check-ups, there was a Zimbabwean man going for his operation for thyroid and I heard them asking that guy if he is a foreigner and whether he has a permit. Then turn to me and ask the same question. They after said that the operation is too expensive. We must go back to Zimbabwe for that operation.

(Migrant FDG, WS550088)

Whether the denial of certain treatments, such as operations, is purely a resource constraint issue is debatable in the view of migrants. Given the context and negative attitudes some migrants have admitted to facing, they describe an underlying attitude of xenophobia involved in this denial of services. Some feel that if South Africans are not denied certain treatments, and they as migrants are, then discrimination may be the true reason. Xenophobia and discrimination are further discussed in a subsequent section.

g. Missing Patient Files and Misdiagnosis Issues

Migrants also shared accounts of their clinic files being missing on the day of their appointments, and of being denied services because there is no record of their health histories. This caused frustration and affected the way that migrants feel about the clinic and trying to access care. Some felt that the clinic did not give their health the importance it required, and all felt upset about the inconvenience it caused them.

While the importance of continuity of care is discussed in a later chapter, here it is noted that for patients with conditions requiring on-going care, it is essential that their treatments not be interrupted if they are to have a healthy life. However, migrants reported that their treatments were denied as a result of the clinic having lost their files.

I started having diabetes in 2015 and only that. My only problem now is that I haven't received my treatment because they have lost my file and that there is nothing they can do

because the file is missing.

(Male, 48, Lesotho, Migrant, WS5500103)

CHWs confirmed this, as they have experienced the same issues with their own files, suggesting that like appointments and waiting times, some health system issues faced by migrants are also felt by locals.

And also last month I was there with my ear bleeding and was told my file is missing and my clinic card and that I must do another file and I asked how is my doctor going to know what is wrong with me if I do a new file?

Interviewer: So people's files are missing?

Yes, all the time even now I went there to check if they have found my file but they haven't.

(CHW FDG, WS550097)

Furthermore, some migrants also expressed concern about their diagnosis at the clinic, stating that they were misdiagnosed and put on the wrong treatments. CHWs agreed with this issue, as they faced similar experiences. Those sharing this concern also said it has worsened their health condition.

My baby was diagnosed for TB at the hospital, but was treated for iron at the clinic and she was always getting high temperature. One weekend I called an ambulance and was checked for TB and the doctor said there is too much iron.

(CHW FDG, WS55085-86-87)

Migrants have stated that even their babies have faced the same situation. They have explained that although they themselves had assumed something was not fine, the clinic had not been able to accurately confirm what the issue was. Furthermore, the clinic had given incorrect treatment, which worsened their children's health. CHWs have faced the same issues. In the incident

mentioned below, it is only after they went to the hospital (in Worcester) that they were able to confirm what was wrong, and the misdiagnoses and/or lack of diagnosis issues from the clinic were surfaced.

> *My baby was diagnosed for TB at the hospital, but was treated for iron at the clinic and she was always getting high temperature. One weekend I called an ambulance and was checked for TB and the doctor said there is too much iron.*
>
> *(CHW FDG, WS55085-86-87)*

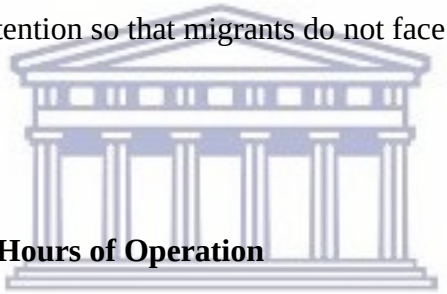
Still others spoke about receiving the wrong set of results from the clinic, causing them confusion and frustration. In the focus group discussions where this was discussed, the tone and frustration gave the impression that this was a topic the migrants had discussed among themselves too. CHWs in the study confirmed facing similar experiences when they went to the clinic to pick up results for migrants, as well as for themselves.

> *Like yesterday one of the volunteer CW (community worker) went to the clinic for testing and told me they gave her wrong results, as she went for high blood test and the result comes back to say she has four diseases.*
>
> *(CHW FDG, WS55085-86-87)*

The issues of missing patient files and patients being misdiagnosed at the clinic are important health systems challenges which must be addressed, as migrants claimed that these factors have worsened their health, increased mistrust in the health system, and acted as an access barrier. While there may be a possibility that one impacts the other, from the data it has not been evident that people made any connection between lost files at the clinic and migrants using other people's IDs, as these appeared as separate compartments in their narratives. Migrants experienced lost patient files as an administrative concern, and negligence on the part of clinic

staff. Using other people's ID, and the confusion with files that resulted from it for the clinic staff, was a separate issue that the clinic staff described; migrants did not acknowledge that their use of other people's IDs may cause any challenges for the staff. This was discussed above in the section on strategies used to navigate access.

Along with this, co-infection between HIV and TB is high, and often patients undergoing treatment for one may be prescribed medication for both. Thus, in understanding the reports and concerns of possible misdiagnosis, it is important to recognize that while the concerns migrants voiced may be accurate, there is also the possibility that the patient may be mistaken. Regardless, these concerns must be given attention so that migrants do not face avoidable deterrents in accessing care.



h. Clinic Location and Hours of Operation

The location of a clinic is an integral part of planning for access, especially if it is the only one serving a large population as is the case with the De Doorns clinic. De Doorns is a heavily populated town and for those migrants who live close to the clinic, they find the clinic to be accessible in terms of location. However, for those who do not own a means of transport, if the clinic is not easily accessible by foot it becomes difficult for them to visit. Migrants in this study largely complained that the clinic location is not suitable for them, especially those who do not live in the centre of De Doorns. When the weather is not ideal, this adds an additional difficulty for migrants walking to the clinic, particularly if they are taking their children with them. To make access easier, migrants suggested that a mobile clinic closer to their accommodation would be preferable. This will allow for everyone to be able to walk to it, particularly women with

children.

> *Yes (it is far). Or we can have a mobile clinic maybe twice a week or three times a week that will help a lot. If you can go behind that mountain you will see that there are lot of people there including old people.*
>
> *Researcher: You don't find that people have been able to access the clinic enough?*
>
> *I don't think so. They will be happy for it because especially when is raining you have to go the clinic with the baby or find that one is pushing one on the wheelchair.*
>
> *(Female, 29, Stofland, Migrant, WS550062)*

Furthermore, because migrants claimed that the only way they could access services at the clinic was on their given appointment day, they needed to transport themselves from their place of work on the farm to the De Doorns clinic on that given day and time. This was a challenge for them, as the farms are located far from the De Doorns clinic, making transport expensive as they have to pay out of pocket since the farm truck will not bring them back. Along with this, due to long wait times at the clinic, many people were hesitant to come to their appointments because they may not be able to return to work that same day. CHWs had witnessed migrants facing these challenges, and discussed them during their focus group. The quote below confirms the interconnectivity of the various barriers, and the impact of these on the decisions migrants make and how they feel about their options.

> *Let's say is the same but what happening here is that transport is a problem for some of the farm people, because is very far from the clinic and [there] is only one clinic here and everyone is coming to this clinic. Let's say is three clinics other one is at Orchard and the other one is at Sandhills, but this one is for the farm workers and is very far. Some people don't want to come here because they have to wait the whole day for the service and when they have to go home is far by foot and the owners used to help with the transport, but they are not doing it anymore.*
>
> *(CHW FDG, WS550097)*

The hours of operation are also integral in determining whether migrants are able to access the clinic. Along with the location of the clinic, participants in this study expressed dissatisfaction with the clinic operating hours. As they are transported early each morning to work on their respective farms, and the farm trucks bring them back between 4pm - 5pm, it is not possible for them to visit the clinic after work, which closes at 4pm. They cannot go to the clinic before their work truck arrives either, as the clinic is not yet open. In the rare event that they do not use the farm truck in the morning and plan for their own transport, going to the clinic as it opens still leads to long wait times, meaning they often miss an entire day's work and income. Migrants therefore advocated for a facility with later closing times.

> *...but the closing time is not okay because they close too early. At 3:30 pm everyone is done working. Whether you have been helped or not, they close the clinic. Their closing time is too early but the opening time is okay.*
>
> *(Female, 34, Eastern Cape, Migrant, WS550060)*

Some migrants went further, stating that they wish for a clinic to be open around the clock. They shared incidents where women delivered babies at home because the clinic was closed. While they described calling an ambulance in situations of emergencies, migrants explained that not all instances allow for enough time to be taken to the nearest hospital, which is in the neighboring town of Worcester, 34 km away.

> *Hai, I don't like these things of closing a clinic for me. A clinic should be open 24hours because sometimes a child gets sick during the night and have to wait for the next day to take the child to the clinic. As for me the clinic should have people who work during the day and throughout the night.*
>
> *(Female, 34, Eastern Cape, Migrant, WS550056)*

The clinic is closed on weekends, and many migrants also expressed concern with that.

I wanted to ask why the clinic closes during the weekend, because people get sick during the weekend too, people like me.

(Female, 45, Queens Town, Migrant, WS550061)

The location, hours of operation and the appointment system were all cited as challenges to accessing services for the migrant population in De Doorns.

It would be good to build a clinic closer to us, especially for the children who get sick during the night so that you can be able to walk in to the clinic without appointment.

(Female, 36, Mphumelelo, Migrant, WS550067)

i. Impact of Discrimination on Access

Migrants discussed facing xenophobic attitudes which make it difficult for them to enter the system. They expressed frustration and anger during interviews and focus groups when explaining the fact that being a foreigner has made it harder to access services. While the quote below mentions expecting to be treated as a fellow African, the African theme or a discussion of identity based access expectations has not been heard elsewhere in this study. Migrants conveyed a sense of despair, as they described continuing to attempt accessing services.

As Zimbabwean, we going to die here because they can't help foreigners, as I don't understand that when operating are they operating me or that paper?

Researcher: So this is frustrating because we trying to get services but we not getting through.

Yes, because they don't see us as human being. We are all African.

In Zimbabwe we have foreigners (all nations) but we are equal...but it's a different story here in South Africa and I don't know what the problem is with this country.

(Migrant FDG, WS550088)

While participants of this study did not report frequent violent attacks towards them, as has been

seen in accounts of migrant experiences in past years, they did share instances where they were treated negatively due to their 'foreigner' status. Migrants experienced a seemingly xenophobic attitude from staff when attempting to use services, and language barriers between them and clinic staff played a role in worsening the situation. Migrants complained that staff does not try to understand them, and instead send them home in their ill state. They shared frustration about the fact that there appears to be no interest or willingness for staff to assist.

> *Yes there is plenty of racism in this area. The first day I went to the clinic when they told me to set an appointment. The nurse saw that I do not understand what she was saying and then she told other to let me go home. Then I told her that don't do that to me. You are an employee and I am your patient, but she was not eager to listen to what I was saying, so that we can understand each other and be one family and give me the help I needed. Because when you help someone, you have that dignity of helping a person.*
>
> *(Female, 24, Eastern Cape, Migrant, WS550079)*

Migrants also shared negative experiences of being deprived of what they consider to be basic necessities for their particular health condition. The quote below describes a pregnant woman close to giving birth, who was denied a bed and food the entire night because she was a migrant, while other local patients around her were provided with both. Situations like this bring to light how attitudes of xenophobia can translate into worsened health for migrants.

> *When you are Sotho and at the hospital you are not offered a bed or food. Because I once went to the hospital having labor pain as I was pregnant and on my arrival I could not get any assistance because a Sotho and also heard one of the nurse asking the other if I am Sotho. Then I was taken off the bed to a chair for the whole night and without food but food were just passing in front of me just because am Sotho. The next morning of one of them asked if am okay and I just said yes knowing very well am not at the same time I developed swollen legs.*
>
> *(Migrant FDG, WS550098)*

j. Impact of Violence on Access

Violence in the community was also highlighted as a factor impacting the lives of all migrants. All participants who were asked replied that they feel unsafe to some extent at all times. CHWs also shared the same concerns, both for the migrants and for themselves, as they walk within the community for their own work. They explained that there are frequent fights and stabbings in all parts of De Doorns, many of which resulted in serious injuries or even death. Chapter 6 will discuss violence as a major contextual determinant of health; here we highlight how violence intersects with key elements of the health system, such as emergency transport services.

As discussed above, migrants report that response times are slow when they call EMS, compared to their local counterparts, and this impacts their health negatively in moments when they have been faced with violence and require urgent care. They also complained that the De Doorns police are selective in their response times, basing their services on the populations contacting them.

> *We do (call police), but they take time to arrive and sometimes they arrive when a person has died.*
>
> *Researcher: So the police are not providing the safety that you need?*
>
> *Yes there is no safety and we don't believe in them.*
> *I only have two years here and police are not doing their job properly because people are being killed andarrest them to release them later. As for people from Zimbabwe they are not being taken good care.*
>
> *Zimbabweans are the least people to be cared and they (police) don't have problems (being like that).*
>
> *(Migrant FDG, WS550098)*

This will be explored in more depth in the following chapter, as violence is one of the major issues described as being a barrier to continuity of care.

This section and the one preceding it have described xenophobia faced by migrants, alongside their experiences of living in a context of violence, where they feel and face fear in their daily lives. These issues are connected to their health and access to health services. Violent attacks impact their physical health directly, and the constant stress of living in fear, in a community they find unsafe, impacts their mental health. Not being able to access services fast enough due to attitudes of xenophobia (which result in slow response times from EMS) also impacts their health. Along with this, not being given the same treatment as locals when at a hospital or clinic not only negatively impacts their health on that given day, but also acts as a deterrent for future clinic visits. Issues of violence will also be discussed in more detail and depth in the next chapter, where continuity of care for migrants in a context of violence and poverty will be explored.

5.4 CONCLUSIONS

As this chapter has shown, numerous issues have been highlighted as challenges to accessing care for migrants in De Doorns, and these may be clustered in a number of larger themes and challenges. For example, access issues are impacted by perceived xenophobia in how migrants are ill-treated when they go to the clinic, when they are denied care, when ambulances take longer to arrive when migrants place the calls, and when some operations are not conducted because it is expensive. Location, staffing, challenges with ID, and language issues are a result of poor planning of services, but also of being under-resourced, and a level of non-responsiveness to migration as a fact of life. If some major issues can be addressed by sector-wide changes instead of migrant-focused changes, as some issues such as long wait times and challenges with the appointment systems are faced by local populations also, this may strengthen the overall health system while allowing the migrant population the care they require.

Despite the numerous challenges faced, migrants, CHWs and staff alike reported that migrants continue to attempt and use services. While accessing care was not expressed as a priority on its own, migrants stated that they were in De Doorns to earn an income, and this is only possible if they are healthy to work.

Researcher: Do you think migrants know that health is important to them?

Yes, they do better than local people. Even defaults are higher on local than migrants.

(Female, 35, originally from Free State, CHW, WS550091)

CHWs also explained that migrants ask for help when needed, and follow up on their treatments. They confirm that migrants try to stay healthy but are facing barriers and being deprived of the care required.

I can say they care about their health. Just that they don't get the service they deserve and also I can say they care more than our local people, because they always ask us and make sure they go to the clinic.

They do follow up.

Researcher: So I am hearing that they are keen on their health?

Yes.

Especially the Zimbabweans, they really care about their health.

(CHW FDG, WS550097)

Even while most migrants expressed concern about the challenges faced while trying to access care, this study has shown some migrants being satisfied with the current health system and their interaction with it.

One explanation of this apparently contradictory view may be that many migrants come from countries with health systems that are more inaccessible or unsatisfactory than the one in South Africa. Hence, their experiences with this current system have been better in comparison.

> *My health here is better than it was in Zimbabwe, because we don't walk a long distance to take treatment and we don't pay (for services) as in Zimbabwe.*
>
> *(Female, Zimbabwe, Migrant, WS550111)*

This chapter has presented health systems challenges identified by migrants as affecting their access to care. The next chapter explores migrants' lives in relation to staying healthy and maintaining continuity of care under very difficult circumstances.

CHAPTER 6:

SECURING AND MAINTAINING HEALTH: CONTINUITY OF CARE IN A CONTEXT OF VIOLENCE AND POVERTY

6.0 INTRODUCTION

This chapter discusses how migrants experience their lives and the health system in maintaining health and securing continuity of care. Continuity of care pertains to all medical concerns which require treatment on an on-going basis, such as what is needed with chronic conditions. It addresses Objective 3 of this study, which seeks to explore how agricufltural rural migrants in De Doorns secure ongoing access to and continuity of care across jurisdictions over time.

> *The good thing is that I am able to go to work and get money to support my family. The bad thing is that the place is not safe but I am risking my life so that I can support my children otherwise no one will do that for me.*
>
> *(Female, 39, Zimbabwe, Migrant, WS550090)*

The participants in this study were in South Africa (and at the time of this research, in De Doorns) for economic reasons: they traveled to a place where employment is available to them. Because agricultural work is seasonal and because wages are low, these migrant workers have had to move frequently in order to remain employed throughout the year. Many reported health conditions which require ongoing treatment, and frequent movement posed challenges in adhering to prescribed treatments.

In addition to issues related to mobility, migrants, CHWs, clinic staff and hospital managers have reported other challenges that migrants face in being able to successfully and consistently manage their health conditions. While some issues are the same for both migrants and the local population, others are particularly relevant to the migrant population due to their travel patterns and the conditions of violence and poverty in which they live.

This chapter begins with a discussion of how migrants navigate access to health and other services by prioritizing health and exercising agency in securing healthcare and ongoing health. It continues with a deeper exploration of migrants' experiences of the health system, focusing on the transfer and referral system, and their overall levels of satisfaction with health services. It then steps outside of healthcare to examine the two main determinants of both health and health behavior reported by study participants: pervasive violence and physical insecurity, and poverty

in multiple dimensions. These two factors are shown to be interconnected with each other, and with the health system and care-seeking behavior. The chapter then comes back to migrants' perspectives on health and health behavior outside of healthcare settings.

6.1 NAVIGATING THE HEALTH SYSTEM: ACCESS, ADHERENCE, AND AGENCY

Migrants participating in this study experienced many challenges in managing their health and securing continuity of care while living in De Doorns. This section explores how migrants navigate access to, and continuity within, the health system and other important public services such as policing. Interviews revealed varied experiences and strategies, as well as some gaps in knowledge and some expectations which differed from those of professionals within the health system, but an overall picture emerged of people who are actively seeking – and acting – to maintain and improve their own health in the face of extremely difficult circumstances.

While some migrants were diagnosed with health conditions before their arrival and travelled to De Doorns in poor health, others explained that they developed illnesses after they reached De Doorns. Challenges faced at various steps of accessing services were identified. For example, the appointment systems discussed earlier, which migrants have claimed is essential in order for them to receive any services, is experienced as negatively influencing the outcomes of their clinic visits.

The quote below, aside from highlighting frustration, explains how treatment can be impacted when migrants are not seen on the day of their visit, as well as how one problem can lead to

others.

> *I am a person who likes to ask and know where important stuff is, so when I arrived I have asked her (neighbor) where the clinic, post office and which side is the town. So she said there is the clinic. Because I had to go to take my prevention (birth control) treatment, I use tablet and the one I had finished, and [I] was never told about the appointments. Normally when my treatment date is close, I will go and collect my tablet. I will go to the clinic in the morning and come back with what I want in the clinic, but when I arrived to take my tablet, I was told to make an appointment and [was] unsure that I will get my tablets. But then I asked them, what if I was going to sleep with a man and get pregnant? How many children would be in SA and how many abortions will be conducted, just because they refuse to give me prevention tablet today?*
>
> *(Female, 24, Eastern Cape, Migrant, WS550079)*

Findings have shown that the management of migrants' health conditions has been negatively influenced by the various health systems challenges discussed in Chapter 5. One of these challenges is the issue of misplaced or missing files at the clinic, and migrant patients cite this as a reason for missing their treatment, and hence defaulting. While in some instances the practice of sharing identity documents to be able to access care is likely at the root of misplaced files, other examples suggest that it is a frequent problem, and that it particularly affects people with chronic conditions who need continuity of care.

Despite the challenges faced, the frustrations expressed and the deterrents placed in their way, migrants throughout this study have shown that they continue to attempt to use services. In the list of priorities in their current lives, migrants have stated that health was ranked high.

> *I take care of myself with the instruction from the clinic. Because they are lot of patients at the clinic and the sisters tells you not to sleep around and gives us condoms to protect us. I think is your duty to take care of yourself.*
>
> *(Female, 40, Zimbabwe, Migrant, WS550112)*

Interestingly, the default rate among this population was seen by CHWs as being lower than that of locals. It is expected that migrants would have high default rates due to mobility, vulnerability and the various lack of access barriers presented. Thus, for them to be seen to have lower rates than locals confirms their motivation to become and remain healthy. Whether their default rate is lower in reality is a separate issue that further research may be able to confirm.

> *Researcher: Do you think migrants know that health is important to them when you speak to them?*
>
> *Yes, they do better than local people. Even defaults are higher on local than migrants.*
>
> *(Female, 35, Free State, CHW, WS550091)*

Most migrants within this study have relatives and/or friends in De Doorns who played a part in bringing them here, and who continue to support the migrants in various ways. While one way is through (limited) financial support, another is by providing them with information about where resources are located and how to use them. Migrants have described being informed by those in their support systems on how and where to access health services, and this direction in the navigation of the health system was shown to be important in the care initiation and management process. When someone in their personal network promotes clinic visits and is being diligent with treatments, they feel inclined to listen, and consequently to manage their health better.

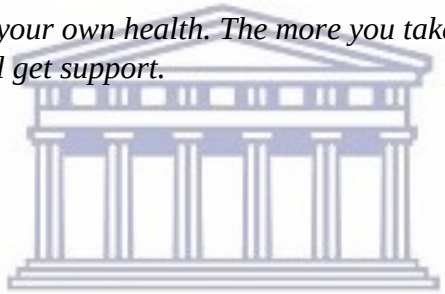
> *My uncle helped me after seeing my health and took me to the clinic and shows me how things are done at the clinic and since then I have been taking my treatment accordingly.*
>
> *(Female, Zimbabwe, Migrant, WS550111)*

Along with this, migrants shared that once they find and go to the clinic, the staff provide them with valuable information on how to take care of their health. While some are individual consultations, other information sharing is done in group sessions. Those who have reported a

positive experience at the clinic have not mentioned facing language barriers as a challenge. This may be because translators were available during the group sessions. Alternatively, during the individual experiences, they may have gone in at times when certain staff (counselors who speak several languages) and other migrants (who served as translators when their peers needed it) were present.

The findings also showed that these individuals are aware of the importance of living a healthy life, and possess an attitude of self-responsibility towards maintaining good health. CHWs also shared the same sentiment regarding individuals taking agency for their own well-being.

> *You are responsible for your own health. The more you take responsibility of your own health, the more you will get support.*
>
> *(CHW FDG, WS55085-86-87)*



6.2 CONTINUITY OF CARE: MIGRANT EXPERIENCES WITH THE TRANSFER SYSTEM

Agricultural migrants in the study moved frequently for employment, between farms within De Doorns and between different parts of South Africa. Many also traveled back to their homes of origin whenever they had time off from work ("dry" season) and/or when it was financially feasible. Those who have been working seasonally, and only on the grape farms in De Doorns, reported going home for an annual or bi-annual visit for several months until the grape season started again. Those who worked on farms growing crops other than grapes went home for shorter periods of time, as the next crop's harvest season began not long after the grape season ended. While destinations, frequency of visits, and length of time away varied, this research

found that the migrant agricultural workers in De Doorns did not simply migrate to the area and remain permanently, but rather continued to lead noticeably mobile lives. A small number reported staying in De Doorns permanently, but most respondents moved at least once a year and usually more often. While for some it was to go back to their home of origin, for others it was to another farm for work. In order to effectively manage this mobile population, the De Doorns clinic has put in place a transfer system (also known as a referral system) with the intention of minimizing challenges arising from frequent mobility. The transfer system includes both a transfer letter and the dispensing of enough medication to last migrants until they returned to De Doorns, or until they reached their next health facility.

The transfer letter contains vital health and treatment information, and is issued by the clinic and given to the migrants as they leave De Doorns. It was intended to be submitted by the migrant to the health facility at the other end of their travels, so that at all times a health facility within close proximity to the migrant was knowledgeable about what treatment(s) a patient was on.

Migrants in the study were aware of the transfer system, and the clinic and CHWs had informed them of its purpose. They also knew what benefit it had.

> *Researcher: Who told you about the transfer?*
>
> *The doctor. They said is very important for me to take a transfer especially moving or not coming back.*
>
> *(Female, 41, Zimbabwe, Migrant, WS550110)*

Some migrants also stated that a transfer letter was given to them in their country of origin as they were coming to De Doorns.

When I first got here I asked if there's a clinic and where is it, I asked my sister. I take high-blood treatment, so when I left home they gave me a transfer letter to come continue with treatment here. So I went and got an appointment date, which is where I'm coming from now and was delayed till 3pm but I got there at 9am.

(Female, 42, Lesotho, Migrant, WS550051)

In addition to the transfer letter, migrants, CHWs and clinic staff reported that the clinic provided migrants with one to two months of medication. CHWs and clinic staff explained that the referral letter and extra pills were meant to prevent patients from defaulting on their treatments.

Researcher: How long do you give the medication for, say they go away for three months or five you give for that long or is there time you have?

If you go away say for two months you get medication to last you for two months and a transfer letter.

Researcher: If I leave for four or five months, they don't give me?

I think they give you because one my patient was leaving for building construction work and ask me to get him medication for two months and the clinic did give him.

(Female, 28, Orchard, CHW, WS550046)

Although this practice was not in place even a few years ago, conversations with staff did not provide any details about how this was initiated, but rather suggested that it was a normalized and integrated part of the services they provided for mobile populations. A senior manager in the provincial health system has confirmed that a draft patient's migration form is currently (2017) being worked on (personal communication, October 31, 2017).

Clinic staff and CHWs have reported being diligent in sharing information about the letters and offering extra medication for the trip, and CHWs have explained that the response from migrants

has often been a positive one.

(Migrants) must get a transfer letter as some leave their medication behind.

Researcher: So this transfer system is working?

Yes it is working and is better when you have it because they will know background when you come to the clinic but if you don t have it is a problem.

Researcher: So your patient when they leave do they come to you for a transfer letter?

What they do is they ask but I don't give one. I just tell them to the go to the clinic to get one and they do so.

Researcher: So you encourage people to get transfer letters. Are they actually doing it?

Yes they do and also I hear from the sister that the patient I have sent for transfer letter has come.

(Female, 39, Worcester, CHW, WS550092)

CHWs and clinic staff have repeatedly emphasized that migrants know about the availability and importance of these letters, as they have been personally informed and encouraged to use them.

They get a transfer by the clinic, to where they are going and show a transfer to be able to continue with their treatment.

Researcher: Tell me...are all of you actually seeing this is happening? Are people bringing their transfers, and taking transfers?

Some do and some don't because the clinic sends us for defaulters and if you have a transfer the clinic will know.

At the same time is the patient responsibility to make sure that when they leave, they have the transfer letter.

Researcher: Do they know about the transfer system?

Yes, they know.

Who tells them about the transfer system?

The clinic.

Also us (CHWs). If the patient tells me that he or she is leaving, I will tell him or her to

go to the clinic and get a transfer.

(CHW FDG, WS550097)

CHWs have also reported assisting migrants in receiving these letters from the clinic before their departure, especially when language barriers were concerned.

Researcher: So in terms of treatment if I am here today and you help me to start a treatment and then tomorrow I go to a farm in the Eastern Cape, what is it that happens?

You have to go the clinic to have a transfer letter that is written all your details and the name of the tablet and when you get to the EC they will give that person those tablets.

Researcher: So your role in this is what? You help them with the paper?

I help them to get the papers because some don't speak or understand Afrikaans.

(Female, 29, CHW, WS550062)

On the other hand, CHWs, clinic staff and hospital managers said that some migrants still did not use transfer letters despite being knowledgeable about its significance. The quote below also shows the responsiveness of clinic staff in being willing to go beyond their official job description to address continuity of care challenges.

You see sometimes they come without the transfer letter and without the medication, so you just have to believe them and give them the medication without the transfer letter and medication. Sometimes we call which ever clinic is from to get the information. Otherwise we must give them the medication.

(Male, Clinic staff, WS550109)

CHWs, clinic staff and hospital managers have also noted that default rates may be negatively impacted by the lack of transfer letters being used by migrants. Interviews and care trajectories have shown that not having the letter makes it difficult for care providers on both ends to serve migrants.

The reason could be when they move, they don't take their transfer letter and it gets

difficult for them to access care where ever they are. And when they come back still they don't have transfer letter and their CD4 count is lower, and must start the process again. Really they must work together with our healthcare workers. And they are doing the same with their babies, where they will tell you they have left the baby's clinic card back home and we have a big problem of diarrhoea.

(CHW FDG, WS55085-86-87)

In instances where migrants have returned to De Doorns without their transfer letters, care providers stated that some migrants have been found to be in worse health than when they left. They explained that not having a letter and not knowing what stage of treatment a patient is at made it difficult for them as service providers, but also for migrants as the patients who were suffering due to gaps in their treatments.

Researcher: So are you finding that people coming from other countries bring the referral letters or not?

Sometimes they don't and they come very sick so the clinic must help them.

Researcher: Are they actually helping them?

Yes, they do because if one dies from not being helped the clinic could be in trouble.

(Female, 45, Clinic staff, WS550096)

Hospital management explained that referral letters are not always reaching the other side, as migrants travel long distances, using multiple modes of transport, and may lose the letters on the journey home, or back. The letter may get taken in where they first stop for service, so it may not make it to their end destination (Female, Hospital manager, WS550115-116).

As not everyone has been travelling with transfer letters, and others have commonly run out of their medication supply, ensuring continuity of care even with the transfer/referral system in place has been challenging. While it would have been helpful, the De Doorns clinic has not been

able to establish links with the other clinics that the migrants use. Migrants move to different countries and towns for different crops, and in a context where there is not a critical mass of people going back to the same health facilities or same town, but rather to many different towns, provinces and countries, it is not easy to establish links with such a large number of facilities (in Kwa-Zulu Natal, Zimbabwe, Gauteng, Lesotho and elsewhere).

Overall, most of the interviews reported here confirm that the referral letter, and supplying migrants with medication to last them during their time away, does make a positive impact when used correctly. However, it continues to be challenging to manage care for migrant populations, as frequent mobility impacts a migrant's continuity of care and adherence to treatments.

6.2.1 Satisfaction with the Health System

While many of the migrant narratives emphasize problems or dissatisfaction with how care is organized and delivered, others express being satisfied with the care they received. Managing care for a mobile population certainly holds particular challenges, yet some migrants said that they received services which met or exceeded their expectations. As the quote below shows, some migrants came to De Doorns in ill health, not having received the treatment needed in their home countries, and the health system they encountered in De Doorns has improved their health.

> *Yah. That I am very satisfied with the service I receive here as I came here very sick and thin. My mother can't believe it that I am actually weak because she saw me when I leave Zimbabwe that I was very sick and every time when I eat I will spill the food so it was very bad for me until I arrive here and start to receive the treatment and I get very emotional with the kindness that I receive every time I visit the hospital or the clinic.*
>
> *(Female, 41, Zimbabwe, Migrant, WS550070)*

Some migrants also stated that the fact that services are free in South Africa, unlike in some of

their home countries, was an access enabler for them.

> *Researcher: Was there any cost for your treatment (TB/Meningitis)?*
>
> *No, everything was free including the food.*
>
> *(Female, 41, Zimbabwe, Migrant, WS550110)*

Perceived quality of care is a result of a complex combination of history, expectations, and experience, meaning that satisfaction may or may not indicate that the services offered to them were of high quality. While this may be the case, some positive experiences may be reflective of the fact that South Africa, with all of its challenges, has a better health system in place than the country they had left behind, and that in the overall balance of their living conditions, these services are on the positive side of the scale.

6.3 THE CONTEXT OF SECURING HEALTH AND CARE: SOCIAL DETERMINANTS OF HEALTH

Two themes predominate in all of the migrant and CHW narratives, whether about securing initial access to care or securing continuity of care and maintaining adherence: violence and physical insecurity, and poverty. These two themes are seen as both distinct, and closely interconnected. They are also seen as interconnected with how health and other public services are or are not provided, how people take action to protect their own health, and how people view their overall lives in De Doorns.

The WHO's *Closing the Gap in a Generation* report reinforces that, "access to and utilization of health care is vital for good and equitable health", and that, "the healthcare system is itself a social determinant of health, while being influenced by and influencing the effect of other social determinants" (WHO, 2008:8). Along with this, the report states that "gender, education,

occupation, income, ethnicity, and place of residence are all closely linked to people's access to, experiences of, and benefits from health care" (Ibid). This study's respondents touched on all the main social determinants of health, and this reinforces that there is a strong interconnectedness between them.

6.3.1 Violence and Safety

Violence and lack of safety confronted respondents in their daily lives in both Lubisi and Stofland, strongly affecting how people lived their lives. Migrants make up a large portion of the population in both these areas, and many were hesitant to leave their homes, particularly with any valuables, for fear of being robbed, stabbed and/or raped. Whether the locals felt the same level of fear is uncertain, as the study did not include them. However, informal conversations with locals indicated that while they too experienced violence and safety issues, it was at a lower level. A potential reason could be that migrants were thought to have money on them, as everyone knew they had come to earn a living and saved money to send home as remittances. Living in a violent community where their safety is a constant concern put migrants in a mentally stressful state, further compounding the survival challenges they face:

> *We have problems with thieves because they rob with our last money when going to the shops to buy food for our children and if you don't want to be stabbed, you shall give them all you had and be left with no money to buy food for your children. The other day they wanted to rape [a] Sotho lady and took her two phones, hand gunned, and it was during the day so am scared to walk alone to town. There is no safety in De Doorns and crime is at large.*
>
> *(Migrant FDG, WS550098)*

The interviews and life experiences reported in this study reveal how healthcare, health status, and violence and insecurity intersect for this population. Violence can lead directly to injury and death, but the repeated accounts of waiting times – especially for ambulances, as discussed in

Chapter 5 – show that the health and policing systems are equally seen as the "causes" of poor outcomes, including death. The quote below shows that speaking a different language is enough to identify someone as a foreigner – and possibly result in non-response.

> *Researcher: The rest of you call an ambulance as well?*
>
> *Yes we did.*
>
> *Yes, they take hours, especially when you call speaking English, they can tell you from far.*
>
> *(Migrant FDG, WS550100)*

Respondents reported that when a local person calls for emergency services, a fast turnaround time is experienced. Hence, when possible, migrants use this strategy.

> *Researcher: Does this discourage you to call the ambulance then? So when you have an emergency, what do you find yourself doing?*
>
> *Because I am sick by that time, I will give the phone to somebody else or my landlord and that makes it easier.*
>
> *(Migrant FDG, WS550100)*

However, when migrants are severely injured, and are not able to find a local person to facilitate access for them in a timely manner, their health and lives are put in jeopardy. Reinforcing the need for emergency services, migrants also described an increase of violence in recent years, with the community of Lubisi said to harbor more violence than the community of Stofland.

> *Life around Lubisi was good but now there is too much violence and not safe. The people who cause such violence are mostly Sotho people so, this place have changed.*
>
> *(Female, 29, Lesotho, Migrant, WS550104)*

Migrants throughout this study expressed concern about the large Sotho (originating from Lesotho) male population, blaming them for increased violence, particularly in Lubisi where they

are highly concentrated. It was repeatedly reported by (non-Sotho) migrants that the Sotho men were at the root of frequent violence, both amongst each other and towards other migrants. Migrants complained that even simple things they did, such as listening to certain music or wearing a certain color of clothing, had triggered a violent response from some Sotho men. The data has not shown any Sotho women involved in perpetuating violence. Rather, some Sotho women agreed with the accusations, stating that they also experienced violence from some Sotho men. The quote below highlights frustration from a non-Sotho migrant on the unsettling situation they live in.

> *In Lubisi, people are dying every weekend. The Sotho people are killing each other and we just stay in our houses like when you play your own radio, they will come and say what you are playing. They just want us to do what they want.*
>
> *(Migrant FDG, WS550100)*

Such narratives add to an understanding of the violence faced by research participants and the ways in which they try to make sense of this difficult environment. It is important to note that such "blame narratives", with their xenophobic tone, are also recounted by migrants themselves, rather than just being heard from locals.

Alcohol use offers another example of how health, "health behaviors", and social determinants of health such as violence have intersected in this community. While alcohol in itself is understood to have negative impacts on their health, migrants' accounts revealed a seamless connection between alcohol use, nutrition, and violence when people are intoxicated, with harm caused both to the person who is drinking, and to others:

Drinking alcohol makes people not to eat properly and we know that if you do not eat properly your health can be affected and so walking around at night is not safe.

(Female, 34, Lesotho, Migrant, WS550099)

Migrants explained that despite the violent setting, they continued to live in De Doorns because employment on the farms is available. As they migrated for economic reasons, they endured other challenges in return for making an income.

That said, some migrants explained that because the areas have become so violent, they have been in search of opportunities elsewhere, and once other opportunities are found, they leave De Doorns. The quote below describes one woman's decision to leave even if she was not able to secure employment. Luckily in her case, she did find other work and was able to plan to move for that job.

I am only waiting a season to end/ close in the farm.

Researcher: And you then leave for home?

Yes.

Researcher: Are you leaving because of safety or because you have found a job?

Safety is part of it, but I had been looking for a job just that I could not find one that time. AndI couldnot stay doing nothing.

Researcher: If you did not find that job, were you going to leave Stofland?

I had already made my mind that I must leave this place for good because there is no safety.

(Male, 22, Eastern Cape, Migrant, WS550084)

One of the central themes emerging from this study is how violence and lack of safety permeate the lives of the respondents, impacting not only their quality of life (and sometimes survival

itself) but also their health, particularly due to delayed access to emergency services. This pervasive sense of insecurity and danger also intersects with, and must be weighed against, economic survival. The next section discusses poverty and survival.

6.3.2 Poverty and Survival

Poverty is the state of having little or no money, or means of support, to afford the necessities of life (UNESCO, 2018). It impacts health in numerous ways, both directly (through income or lack of income), and indirectly through social relations that are strained under conditions of poverty.

In their stories and in their answers to questions, the participants in this study revealed a clear recognition of the many dimensions of poverty discussed in the literature from the commission on social determinants of health (CSDH, 2008) and in studies showing how chronic stress is associated with socio-economic status (SES), and the social and environmental conditions associated with it. Baum (1999) discusses that crowding, crime, noise pollution, and discrimination are some stressors which migrants face, and that these are also associated with distress, prevalence of mental health problems, and health-impairing behavior. This study's participants were aware of all of these connections. When migrants are not able to afford nutritious food or hygienic living situations due to expensive rent, this directly impacts their physical health, especially over the long term. Similarly, poverty is also seen by these migrants as having negative impacts on mental health.

6.3.3 Financial Poverty

While nearly all of the migrants in De Doorns would be considered "economic migrants", who travelled in order to gain cash income, the respondents in this study overwhelmingly explained that regardless of being employed in De Doorns, they are still financially poor. While some migrants felt that their lives are better than what they had left behind at home (attributing the betterment to having employment and income in De Doorns), the findings show that poverty is still largely a characteristic of their lives.

> *It's a little bit easier here because you can find money, though is not much, but you can still find 200ZAR and I can send it to my children to buy maize meal, whereas in Zimbabwe to find $20 is not easy. You can even spend 2 months without having that $20.*
>
> *(Female, 34, Zimbabwe, Migrant, WS550057)*

Migrants described facing constant financial struggles, and explained that their income from farms was often not sufficient for them to buy necessities, as costs in De Doorns are high in proportion to their farm incomes.

> *Researcher: Is this farm working better than the other ones?*
>
> *Nothing is better, but in this farm we not working hard than the other one. It's only money if I could get 600ZAR per day or 1200ZAR per fortnight I will still not be able to purchase small items, because the price are high and money is little you see, that is how we are living.*
>
> *(Female, 34, Zimbabwe, Migrant, WS550057)*

> *I am working in three farms now. My life now is difficult because things are expensive here so is better to go back home.*
>
> *(Female, 41, Zimbabwe, Migrant, WS550070)*

Along with this, the season for employment has been shortened, giving them less overall income.

> *Now is less work because last time we used to finish end of May, but now is end of*

March. Most of the farms end in March, so the season ends earlier.

(Female, 39, Lesotho, Migrant, WS550090)

Seasonal work was particularly challenging because migrants have families to support all year long, but no income to make that possible. Hence, some worked on multiple farms, as the harvest seasons are at different times. This impacted their continuity of care, as they moved areas and went further away from the De Doorns clinic. While care management was affected by this frequent mobility, migrants still did what was required for them to survive economically.

6.3.4 Dangerous and Difficult Work

The journey to De Doorns, particularly for cross-border migrants, was characterized as being fraught with harsh challenges. Some migrants even went back, not being able to deal with the realities they met with and the type of employment available to them. Work on the farms is strenuous, as all respondents explained, and the quotes below demonstrate some of the issues they faced. These include dangerous working and living conditions, with some migrants being unable to sustain working on the farms due to how demanding it was on their health. While some went back, most returned to the area since the alternative was having no income at all.

I left from Lesotho going to Eastern Cape, Alban North. When I got there I worked as a domestic worker and I felt I can't work and left. I then met with a drug dealer and work with the drug dealer until I leave, because working with drugs is a dangerous job as you always hide from the police day and night. I then went back to Lesotho and realise that I can't just sit in Lesotho doing nothing. I left looking for another job. Thereafter I met with my sister and we decided to come to Cape Town and that is where we discovered about De Doorns. We travelled very late at night and I didn't see anything on the road as it was late. We arrived in the morning around 08h00 and we stayed a week without a job and on the second week that's when we found a job, working for the person by the name of Berry. I couldn't work for the job at all as I was not used to it, so now l have decided

to leave the job and stay at home until the end of season but now am busy selling clothes.

(Female, Lesotho, Migrant, WS550052)

Researcher: What if you don't get a job in Zimbabwe?

I will do nothing, I am tired of working in the farms it's a hard work, because there is no job in Zimbabwe. When the orange season ends next year I just want to stay with my kids.

(Female, 40, Zimbabwe, Migrant, WS550071)

6.3.5 Making the Best of a Bad Situation: "I am able to provide for my mother"

Faced with impossible choices, people have to come to terms with their lives and try to find meaning in them. Some quotes reveal how violence and theft are normalized, almost to the point of banality, in narratives that seek to convey how people view and make sense of their lives as a whole.

It is a bit difficult this year to stay in De Doorns because you only work seasonal and after that you don't have anything to do and to support your family. But life is alright in the community, is just that there are drunkard and thieves that steal our stuff. Currently I am not working, but I used to work in the farms, so the season now has ended.

(Female, 39, Zimbabwe, Migrant, WS550099)

Despite the difficulties in their current lives, the migrants still prefer to be in De Doorns, as they have few other viable options. All participants said that they had dependents, mostly children and elderly relatives, both in De Doorns and their home countries.

As long as there is no employment and no finance in Zimbabwe I will stay here because my children will suffer if I go back home and do nothing.

(Female, 34, Lesotho, Migrant, WS550090)

Regardless of the impact on their physical and mental health, migrants continued working on

farms, as they have dependents such as children, siblings and elderly parents who survive on their remittances sent from De Doorns. While migrants explained that this dependency made it financially challenging for them to live in De Doorns, some have expressed their gratitude at being able to provide support to those who need it.

> *I had no money. I am the oldest child at home and my mother has diabetes, she is not working, does not receive grant money. My mother has a husband but he is not my biological father, he receives grant. I saw that things were tough for me and that I needed a job. My life has changed now because I have money, I am able to provide for my mother.*
>
> *(Female, 34, Eastern Cape, Migrant, WS550060)*

However, while most respondents were employed, their lives had not improved to the extent that they had hoped, yet they continue to work for the sake of survival, for as long as they are physically able. While some respondents minimize the risks and challenges of their lives, all are very much aware of these. Alongside difficult work conditions, safety issues were brought up repeatedly, as both impact health negatively, and the quote below highlights this.

> *It is not like I am planning to stay. It's just that I came here because of the work/employment. Otherwise if it wasn't for that, I would have passed long time ago. Firstly, the place not safe, you have to look for a job, and then you will work and buy yourself a cell phone and they'll rob you. Everything here is not the way I thought it would be when I left Gatjani. I thought I going to find better things, just like when I went to some other place and find better things. But here JOH, Hai, the life here is tough and worse.*
>
> *(Female, 24, Eastern Cape, Migrant, WS550079)*

6.3.6 Poverty, Social Determinants of Health, Health Systems and Behaviours

Further highlighting the link between poverty and the social determinants of health, and continuity of care and health behavior, CHWs reported that in their work with migrants, poverty

was a prime reason for defaulting on treatments, as migrants were not able to afford enough food to take with their medication. The most commonly-prescribed medications for this population were for TB and HIV, and both treatments require patients to take their medication with food, meaning that missing meals leads to some migrant patients skipping their treatment too. This has led to poor health outcomes, and even death for some. This is described in the quote below, which also reiterates the challenge with long wait times at the clinic.

> *Poverty. They don't have food to drink their medication. They are scared to go the clinic because they don't want to lose a day at work.*
>
> *(Female, 44, CHW, WS550063)*

Poverty also has a direct impact on the nutritional intake of migrants, and migrants said that while they know what is healthy for them to eat, they cannot afford those items due to lack of financial means.

> *We do take veggies and they do teach us what to eat at the clinic, but because of money and termination of contract (at the farms), we are unable to afford such lifestyle and all we eat is pap.*
>
> *(Migrant FDG, WS550098)*

Accommodation challenges were also cited by migrants, as well as CHWs and clinic staff, as impacting on the health of migrants, particularly when they first arrive in De Doorns. All respondents stated that living in crowded and unsanitary shacks is directly unhealthy, and contributes to the mental stress and conflict in a violence-affected community.

> *...when I arrive in Lubisi I struggled to get accommodation. I end up staying in a room with seven different people, male and female. And we were always fighting because we were from different background and I stayed there for about two months.*
>
> *(Male, 22, Eastern Cape, Migrant, WS550084)*

Basic requirements such as clean water and electricity are not always available to migrants in their shacks, thus their quality of life and health are impacted by this.

> *The problem is that they don't want to stay in their shacks, as they always ask if I know a person who sell a house or rent it out, because they don't have electricity in their shacks.*
>
> *(Female, 36, CHW, WS550067)*

Poverty also led to migrants actively seeking healthcare. Migrants stated that the hope of free medication motivated them to visit the clinic, as they could not afford medication from the pharmacy, or private medical services. However, health systems challenges such as the appointment systems prevented them from receiving free medication at their time of need and preference, and often the clinic was not perceived to be serving their needs. The quote below reflects frustration at not being attended to without an appointment, as this impacted their care management directly and negatively.

> *Ok, I have never been sick and can't get up, but when I feel like I am getting sick or even headaches, I will rush to the clinics. Even though when I arrived to the clinic and I was told that I should have set an appointment. I did not understand why I should set an appointment when I have a headache now. When you put an appointment they will tell you it's for tomorrow morning at 10H00 am, then you will have to wait for that time and still have to rush to work. I have asked why when I am sick now I have to make appointment for tomorrow, because who know if they will still be alive the following day. Why don't I get help the same day, because I thought clinic was supposed to be a place where you get help quickly and do not have to pay money and buy disprin. Since I do not have the money to buy disprin and I went to the clinic to get them for free, and they tell you that you should set an appointment.*
>
> *(Male, 37, Zimbabwe, Migrant, WS550079)*

These narratives show how social determinants of health, and particularly poverty, intersect with health systems factors and individual behaviors in a context of violence and insecurity of both people and livelihoods. Migrants, CHWs, and health workers were very much aware of both the

individual links between a determinant and health, and of how interconnected they are. Crowded living conditions and infection control issues are related, while poor nutritional in-take is a deterrent to good health, compounded by fears of, and actual, violent attacks and robberies. Similarly, health systems factors such as the appointment system also impact migrant health, and individual or family choices made to cope with complex situations can either improve or worsen health.

6.4 BEYOND ADHERENCE AND THE CLINIC: TAKING CARE OF HEALTH

Considering the conditions in which people lived, it was remarkable how often migrants spoke with enthusiasm and hopefulness about participating in various health-promoting activities and making – or at least trying to make –healthy lifestyle choices. These accounts sometimes seemed strange, coming from people whose meager incomes depended on hard physical labor. For example, exercise was commonly cited as a way of staying healthy. While their work on the farms was heavy manual labor, participants did not associate it with exercise or healthy behavior. Instead, they held two visions in place, one of survival (farm work) and another of health and well-being (choosing to exercise and partake in certain activities). Through the conversations, it felt as if some migrants were repeating health promotion advice which they had been told, while others genuinely believed in the importance of certain activities.

Yes it is very important, like in staying healthy, exercising and drinking water.

(Female, 30, Lesotho, Migrant, WS550050)

Migrants associated healthy behavior with drinking water, as alcohol use was rampant in De

Doorns, and they saw firsthand that overuse impacted health negatively.

> *...just going to the gym and lift some weight, even now I was going to the gym when you come in.*
>
> *(Male, 26, Lesotho, Migrant, WS550059)*

It was interesting to hear young men going to a gym to lift weights when their work on the farms already involved heavy lifting. This showed again that livelihood and healthy living were seen as separate in their minds and in their actions.

In the study, those migrants on treatments also identified the need to take their treatments diligently and regularly, as HIV and TB were cited by the participants as common conditions which the migrant population suffered from.

> *I must always take my pills on time.*
>
> *Researcher: So you are very consistent with your pills?*
>
> *Yes and time - as time is very important.*
>
> *(Female, 41, Zimbabwe, Migrant, WS550110)*

> *Researcher: Any pills you are taking at the moment?*
>
> *Yes, for HIV.*
>
> *I only take ARVs during the night and take them very well.*
>
> *(Female, 25, Lesotho, Migrant, WS550101)*

For some migrants, accessing treatments meant travelling long distances. However, they emphasized that they did whatever was needed to access their medication.

I was working as a house maid and was walking to the clinic every day early in the morning for my treatment then go to work, until April, until I got transfer to De Doorns.

(Female, 41, Zimbabwe, Migrant, WS550110)

As discussed earlier, agricultural migrants moved to De Doorns for employment and income, since neither was available in their countries of origin. Thus, their health is important, as if they are not healthy, they will not be able to work on the farms, which is what their survival (and that of their dependents) depends upon.

Researcher: How important is it for you to stay healthy?

I see it as very important because if I don't take care of myself I will be sick and not go to work.

(Female, Mozambique, Migrant, WS550049)

My health comes first before money because I won't be able to make money if am not well.

Researcher: Where does health fall for the rest of them?

R.A.: They all saying that health comes first as they can't make money while they are sick.

(Migrant FDG, WS550098)

CHWs also confirmed that migrants show agency towards their own health, and this was often expressed in high rates of adherence. They went on to state that the default rates among migrants were lower than that of the local population.

Researcher: Do you think migrants know that health is important to them?

Yes, they do better than local people. Even defaults are higher on local than on migrants.

(Female, 35, Free State, CHW, WS550091)

I can say they care about their health. Just that they don't get the service they deserve

and also I can say they care more than our local people, because they always ask us and make sure they go to the clinic.

(CHW FDG, WS550097)

These and other interviews showed that agency and adherence were closely linked for migrants in this study. The capacity and/or willingness to take action in support of their health, to continue to prioritize their health, and being diligent with taking treatments and following healthcare advice are intertwined. Thus, migrants were not passive with respect to their health or medical advice.

Contrary to assumptions that there are many critical knowledge gaps, the migrants in De Doorns were generally well informed about what good health practices are, and about how they relate to each other. As noted above, alcohol consumption and misuse are common in De Doorns, particularly among men, and violence particularly escalates from Friday evening and continues all weekend, when some people are heavily intoxicated. These issues were seen not only as social issues, but as health issues. When asked about healthy behaviors, many participants commented on alcohol.

Yes. Health is very important.

Researcher: How important is it to you?

It is important to take care of yourself, to avoid drinking alcohol excessively and going out all the time.

(Female, 45, Queens Town, Migrant, WS550061)

Drinking too much alcohol and sleeping around are things that I see are risky to my health.

(Male, 33, Free State, Migrant, WS550069)

Thus, migrants stress the importance of health-promoting behaviors, which are linked back to the importance of access to services and making treatments a priority.

6.5 CONCLUSION

This chapter documented findings about care management issues specific to De Doorns's migrant population, as well as their continuity of care while traveling. Along with this, the experiences of migrants who were satisfied with the health system were discussed. Transfer letters and extra medication given out by the clinic emerged as a major theme supporting continuity of care, as well as establishing positive relationships between the health system and migrants. However, the transfer letter system is imperfect. While some migrants made sure to travel with the transfer letter, others have not used it and returned to De Doorns in a worsened health condition. Still others lost their transfer letters on their journey, impacting their continuity of care.

Two major drivers of ill-health recurred as important themes touching nearly all aspects of health and healthcare. One is pervasive violence and lack of safety. For example, when migrants were on the receiving end of violent behavior and called an ambulance, an attitude of xenophobia and/or racism caused delays in it arriving, placing migrants in a more critical health situation. The second is poverty, highlighting the difficulties migrants faced in living a life where they were not able to afford nutritious food or a hygienic living space which was not over-crowded.

Agency from the migrants in accessing services and their willingness to adhere to treatments,

including prioritizing their health, is important to note and was highlighted by many respondents. However, even with their collective existing efforts, CHWs, staff and hospital managers agreed that further attention must be paid to this population, as they are still seen to be vulnerable to poor health and to be living in very difficult circumstances. As described earlier, despite the high default rate among this population, it was seen by CHWs as lower than that of locals. Continuity of care is essential for migrants because of their frequent movement, and care management once they are put on treatments must be prioritized.

CHAPTER 7:
ROLES AND EXPERIENCES OF COMMUNITY HEALTH WORKERS IN FACILITATING CARE FOR MIGRANTS

7.0 INTRODUCTION

CHWs play a unique role in the primary health care system, addressing the growing shortage of health workers in concert with expanding populations, particularly in low-income communities such as De Doorns (Lehmann & Sanders, 2007). Using people from the community to support certain basic health services to their own communities is not a new concept, as it has been around for at least 50 years and made a positive impact in most scenarios (Ibid). In conversations with CHWs during this study, it was evident that they saw themselves as care providers, and those who knew of CHWs and their services also saw them as care providers.

This chapter presents findings on CHW roles and experiences in De Doorns when interacting with or supporting migrants, and will relate CHWs' explanations of their duties in the community and the challenges they have faced. As the focus of this thesis is on the challenges and experiences of migrants, the chapter's presentation of CHW roles and experiences is structured around the challenges faced by migrants, and in relation to the conceptual framework of the study. Apparent contradictions across accounts will also be addressed here, and further explored in the Discussion chapter.

7.1 SITUATING FINDINGS WITHIN ADAY AND ANDERSEN'S FRAMEWORK ON ACCESS TO CARE

Aday and Andersen's Framework on Access includes five main components: health policy, characteristics of population at risk, consumer satisfaction, utilization of health services and characteristics of health delivery system (Aday & Andersen, 1974). The findings of this chapter are best situated in the category devoted to *characteristics of health delivery system*. Resources, both volume and distribution, are included in this category. It discusses labor and capital devoted to healthcare, which cover staff alongside structures in which healthcare and education are provided, and equipment and materials used in providing services. CHWs are resources in the form of staff.

Organization (including entry into the health system and structure of the system) and what a health system does with its resources are the second part of this category, which discusses how staff and facilities are coordinated and controlled in the process of providing care. While *entry* refers to the process of gaining entrance to the system, *structure* refers to the characteristics of

the system that determine what happens to the patient following entry into the system. Thus, CHWs fall into the *entry* category as they are meant to facilitate entry into the system. Many have also claimed to support the clinic by serving as translators, so they impact the structure of the system in determining, even if in a limited capacity, what happens to patients once they have entered the system.

The findings of this chapter contribute to understanding aspects of health systems which are often hidden, particularly those where significant roles are played by organizations and personnel who are not directly employed or managed by the public health sector. The framework, in turn, helps to see that CHWs and their interactions, with communities on the one hand and health facilities on the other, are very much part of a health system, and that their contributions can be important determinants of access to and continuity of care.

The chapter begins by introducing the CHWs from both organizations employing CHWs in De Doorns, and describing their roles. Next, the chapter describes how CHWs reported facilitating migrants' entry into the health system, which was primarily by bringing migrants into the De Doorns clinic and retrieving their medication from the clinic to facilitate continuity of care. Following this, findings related to *structure* in Aday and Andersen's terms will be presented, as CHWs have explained also being a part of the post-entry system process through translation services. This is complemented by the view of migrants towards CHWs, what roles they feel CHWs play, and what their experiences have been with them. The chapter continues with a CHW case study to illustrate some of the findings presented earlier in the chapter, and concludes with a summary of findings.

7.2 Community health workers in De Doorns

At the time of this study, all the CHWs employed in De Doorns were working with one of two organizations, while one CHW from the study was employed by both organizations. To protect confidentiality, the organizations will be referred to as Org A and Org B.

Org A's main focus is to improve the lives of families and children in need. The CHWs employed by them work in DeDoorns (and the surrounding areas of Wellington and Sandhills), and some of the migrant participants were familiar with their role and existence. A non-profit established in 2006, Org A is a designated Child Protection Organization (Org A website, 2006). The CHWs involved in this research reported that they worked with both the local population and migrants. Although the organizations are not formally a part of the Department of Health (DOH), Org B is funded entirely though the DOH, while Org A has some DOH funding, but this is combined with other private sources.

Org A's website states that they are actively involved in the provision of health services in partnership with the Department of Health, and they provide services aimed at the prevention and treatment of HIV, TB and STIs. De Doorns has a high burden of these diseases, and the NGO offers services such as screening, testing, and counseling for the listed conditions, and for individuals on chronic medications (i.e. hypertension, diabetes, ARV's). This organization employed approximately nine CHWs at the time of the fieldwork, and six (including the pilot interview participant) were interviewed for this study. They were all female and working part-time hours with a flexible schedule, with some working weekends and evenings, based on their availability each week.

The second organization, a non-profit organization (NPO, also considered an NGO) referred to in this study as Org B, also employed CHWs in and for the De Doorns area. Their official purpose is to provide professional and compassionate home-based care, to provide efficient and correct health education to the greater community, and to provide adherence support to patients with a chronic illness. Org B, an NGO funded but not directly managed by the Department of Health, runs an inpatient and outpatient facility caring for the terminally ill. Based in the town of Worcester, approximately 33.5km from De Doorns, they also employed CHWs who lived in De Doorns to serve their own community. Since 2015, Org B has employed a total of 14 CHWs to serve De Doorns, and five were interviewed for this study. Patients are referred to Worcester Hospital if they required further medical care and treatment that Org B cannot provide. Along with this, a social worker was available to help people apply for identity documents such as birth certificates and social grants. CHWs from Org B also provided home-based care services for terminally and chronically ill patients, and support for their families.

The DOH's Service Package for NPO funding for 2017/2018 indicates that the DOH contracts organizations to render the following health services:

1. Intermediate Care;
2. Home and Community-Based Care (HCBC);
3. Community Mental Health;
4. Nutrition projects;
5. High Transmission Area (HTA) projects;
6. NPO-Driven Wellness Centers; and
7. Facility-Based Counseling, including facilitation for clients with chronic conditions.

The DOH's funding choice has resulted in them giving importance to the role and contributions of CHWs.

Personal interactions with both organizations have highlighted their similarities and differences. Both are very involved within the community, and have similar mandates of supporting the population, but their differences are clear in their operating structures. Org A is informally structured, with no uniforms or marked attire, no given supplies for CHWs to take on visits, and no set schedule of when CHWs will visit patients on their lists, although they try to visit each patient once every two weeks (unless there is an emergency, in which case they do the visit earlier). During participant observation, there was no structured record-keeping of each patient visit, and no pre-determined structure of what to cover on each visit with a patient. CHWs at Org B, on the other hand, have marked uniforms, which people in the community used to identify them, and work according to a much more formalized schedule. They report to the De Doorns clinic every morning to complete paperwork and review plans for their workday, have a bag with supplies, and an outline of what to cover on each visit with a patient (although this was also tailored to each patient at the time of the visit). Org B CHWs keep records of each visit, and are diligent with the timelines of when each patient was last seen, and when they would be seen next. Along with this, CHWs from Org B are allowed to write referral letters for their patients, which informed clinic staff about what the patient was experiencing, and how urgently to set the appointment. While CHWs from Org A do not provide this service for their patients, they agreed in their joint focus group discussion that it is very good practice.

During the participant observations, social desirability bias was visible at times during CHW and

patient interactions for the Org B visits. The CHWs appeared to be careful to say and do exactly what was outlined in their job descriptions, and at times the interactions appeared unnatural because the patients were answering specific questions, and not responding in an organic manner. This was not visible with the Org A participant observation visits, as the CHWs did not have clearly defined deliverables for each visit; as a result, the interactions were more casual.

The bias was more evident when the CHWs tried to include the primary researcher; the interaction appeared partially framed for the benefit of the primary researcher. In other interactions where the primary researcher was not a focus of the situation, the CHWs appeared to show more direct engagement with their patients. However, regardless of the social desirability bias, CHWs from both organizations appeared to have built trust with their patients, and a friendly, comfortable relationship was witnessed in all interactions during the participant observation sessions.

7.3 CHW ROLES, CHALLENGES AND EXPERIENCES WITH MIGRANTS

While their work varied in some ways based on the organization employing them, CHWs reported that their roles generally involved supporting the community in their health needs, and particularly those who could not travel to the clinic for various reasons (such as old age, or not being able to physically or logistically go to the De Doorns clinic). CHWs also reported being active in awareness and health promotion activities, counselling, translating for migrants at the clinic, and being involved with social service cases which required their attention. This section also includes CHWs' descriptions of some of the challenges they face in working with migrants.

7.3.1 CHW Roles

CHWs are required to carry out a wide range of duties, extending from basic patient care and follow up, to community education, participation in projects being run by a number of external organisations (Ukwanda, SATVI, MRC), administration and record-keeping. All the information below was obtained from the job description provided by Org B, and from personal communication with a Health Sector Manager (Nov 11, 2017) and a Medical Research Council (MRC) Junior Scientist (Nov 11, 2017).

Basic patient care includes treatment of wounds, ensuring the care is holistic, and referring patients to physicians if the situation is more severe. CHWs also support patients on chronic care, by following up on and tracing patients, and facilitating distribution of the appropriate medication. An important aspect of this is administration and record-keeping, and CHWs are required to submit daily, weekly and monthly records. In a broader community sense, CHWs engage in condom distribution, and door-to-door education and awareness campaigns on TB, family planning, and the administering of vitamins to children. Along with these duties, CHWs often participate in projects established by external organisations. The first of these is Ukwanda, the Worcester campus of Stellenbosch University medical school, and CHWs assist and support Ukwanda students when they are based in the area. In addition, the South African Tuberculosis Vaccine Initiative (SATVI) and the Medical Research Council (MRC) both run projects in the area, and CHWs are expected to comply with the project requirements.

7.3.2 Beyond the Job Description: Translation, Continuity of Care and Outreach

In addition to the duties described above, CHWs reported doing other work that was not

specified in their job description. For example, language barriers faced by the migrant population when trying to access services was reported repeatedly as a deterrent, as discussed in earlier chapters. CHWs confirmed that communication issues are indeed a challenge and say that they assist whenever possible.

> *Researcher: So nobody at the clinic speaks the language of the migrants?*
>
> *Yes.*
>
> *I don't know why they don't mix people who speak different languages like Xhosa and Sotho as we have those people who speak that language here but at the receptionist are only Afrikaans speaking people only. And if you don't speak English you won't be helped.*
>
> *Sometimes we as carer are asked to translate for them.*
>
> *(Female, De Doorns, CHW, WS550097)*

Thus, CHWs balanced their translation services with their existing duties, adding to their work load. While they reported doing this because there was immediate need, they also explained that the clinic itself should consider how to deal with this challenge in the long-term. CHWs expressed the necessity for clinic staff to accommodate migrants who do not speak English or Afrikaans.

> *Also sometimes when you have arrived at the clinic at 08h00, they will ask CHWs to translate for them and by that time I have to go and see my patients - but then I will have to help them as that person need my help. And then next time she or he will say thank you for helping me. Even us as CHW we encounter similar problem at the clinic, but I feel the clinic should make initiation for the community system, because some nurses can only speak Afrikaans and we have Sotho people also. How can they communicate with them? That's a big challenge we have in our community.*
>
> *(Female, De Doorns, CHW, WS55085-86-87)*

CHWs emphasized that this is a pertinent issue as migrants facing a difficult time at the clinic often leave due to frustration, taking their children with them. Hence, it prevents migrants from actually accessing services, even when they have already made the effort to arrive at the clinic.

Language is an issue to where migrants don't speak Afrikaans and that affects their health as some get frustrated and decide to leave the clinic and their baby ends up sick in their home.

Researcher: Are most of the people feeling that way?

Yes.

(Female, De Doorns, CHW, WS550097)

In addition to translation services, CHWs reported supporting continuity of care by assisting migrants with retrieving their medication from the clinic. Agricultural migrants who are employed on the farms are transported to work in the mornings on the farm trucks, so it is difficult and expensive for them to return during the day for an appointment at the clinic to pick up their medication, as they would have to pay for their own return transport. Along with this, most migrants reported not being paid if they missed a day of work. As agricultural migrants, their priority in De Doorns was to earn an income, and missing a day of paid work was understandably cited as not being possible or preferable for them. Hence, CHWs explained that this service was needed to support migrants in taking their medication without interruptions.

What I do is when they ask me I take their clinic card to get medication for them so that they don't lose money for that day or skip work.

(Female, 28, Stofland, CHW, WS550046)

In relation to continuity of care, CHWs explained that they assist in the tracing of patients who have missed their appointments and may be defaulting. They do this by getting lists from the clinic, and going to individual addresses to find the patients. If the patient is repeatedly not home, CHWs ask neighbors about the patient's whereabouts. While it is difficult for them to manage a mobile population, CHWs affirm that it is a part of their role.

Researcher: The referrals, do you help with the referral when the migrants move?

The challenge is that when they move they don't say and also they don't say when they have changed that address and we must look for them which make it difficult to trace.

Researcher: Why are they moving within De Doorns?

You will find maybe they have problems with the landlords.

Researcher: When they move are they still using the De Doorns clinic?

Yes.

Researcher: Then why are you looking for them when they are using the same clinic?

We only look for them when they have defaulted and change the address.

(Female, 35, Lubisi, CHW, WS550091)

CHWs also explained that their outreach activities extended beyond De Doorns, and included the farms on which the migrants worked.

We targeted these three farms because of the owners who had problems in giving their employee time to visit the clinic.

(Female, 29, Stofland, CHW, WS550062)

Visiting the farms was a part of CHWs' outreach activities, and by getting permission from the farmers to host information sessions at certain farms, CHWs were able to spread essential messages to migrants who would otherwise not have exposure.

Diarrhoea also frequently came up in the CHW accounts, as it was a critical and common condition for the population. In fact, a seasonal program had been planned by Org B to address it annually. While adults were also affected by this, children and the elderly were most at risk.

….there are lot of children here who have diarrhoea.

Researcher: So every year there is a diarrhoea season?

Yes but it last until March April but the Hospice is doing it until February.

Researcher: So every year there is more children with diarrhoea?

Yes but it includes old people also.

(Female, 35, Lubisi, CHW, WS550091)

CHWs make a valuable contribution to community development, as they have the potential to improve access to and coverage of communities with basic health services (Lehmann & Sanders, 2007), and have been shown to do this in communities across the world. There is strong evidence that CHWs can undertake actions that lead to improved health outcomes, and their work in the field of child health has been recognized as making a noticeable difference (Ibid). Supporting this, CHWs in this study indicated that they worked with migrant children more often than migrant adults. They explained that the adults departed early in the morning for their farm work, leaving their children behind, and while some children had their older siblings to care for them, others were left with friends or neighbors, and a few were put in a crèche (a daycare center). CHWs employed with Org A primarily worked with children, and shared their experiences of dealing with health conditions such as diarrhoea.

I have worked with migrants' babies during diarrhoea seasons. And with adults they manipulate people's ID, because they want to be helped and they use multiple ID but if you don't have asylum or ID you won't get help.

(Female, 45, CHW, WS550096)

The issues of ID and asylum mentioned above refer to the challenge migrants explained facing when being denied services without proper legal identification. The quote indicates that some migrants shared their own IDs with others who did not have one, as a means for them to gain access to services. While the study could not confirm an accurate number of how many migrants

did this, conversations with this population gave the sense that it was common practice. The issues arising from people sharing each other's IDs, which are tied to their health records and treatment histories, were discussed in Chapter 5. Misdiagnosis is one issue, as medical staff explained that they cannot treat patients accurately when the correct patient files are not presented to them. In conjunction with this, CHWs explained facing the challenge of getting migrants to understand the importance and urgency of applying for asylum documents if they do not have other ID to present at the clinic.

The lack of ID was also highlighted as a challenge in being able to access CHW support. While CHWs working with Org A shared that they have migrants on their list who are not legal, CHWs from Org B explained that there are organizational restrictions for them in helping illegal migrants with no paperwork.

> *Most of them are migrants and out of twelve I can say ten.*
> *Researcher: Are they from parts of South Africa or from other countries?*
> *Most of them are from Eastern Capes*
> *Researcher: What about other countries, Zimbabwe or Lesotho?*
> *No, just South African migrants*
> *Researcher: So you don't have any patient that is from other countries?*
> *No, because ID is needed in order to help them.*
>
> *(Female, 28, Stofland, CHW, WS550046)*

This has made it difficult for many migrants to receive much needed support. Although migrants thought that the Org B CHWs were visible due to their blue uniforms, they also reported not knowing exactly what their roles were, as they had not interacted directly with them.

7.3.3 CHW's Challenges: Safety, Compensation and Gender Roles

CHWs also faced personal challenges while performing their duties. One challenge brought up by all CHWs interviewed was the impact of violence in De Doorns, and the lack of safety that they face.

> *We walk long distance in the rain and sun, there is violence around the community and it is not safe as you can't just answer your phone and also risk when you go to the people's house as you don't know who you find.*
>
> *(Female, 45, De Doorns, CHW, WS550096)*

> *Researcher: Do you feel safe in your job then?*
>
> *No, we don't feel safe even in your own house, because they break in your house in daylight.*
>
> *(CHW FDG, WS55085-86-87)*

The safety concerns described align with those of the migrants, and all participants in this research frequently and passionately described the violence in De Doorns and the fear they face in their everyday lives.

While not a challenge in the same way as safety, some CHWs believed that their compensation is not sufficient for the work they do. However, they also knew that their employment opportunities in De Doorns are limited, which encouraged them to keep their job.

> *Is not enough as compared to the work we do.*
>
> *(Female, 45, De Doorns, CHW, WS550096)*

> *Ahh! We don't get much but I have to do this job as no one can do it for me so I have to carry on.*
>
> *(Female, 20, Smartytown (De Doorns), CHW, WS550093)*

In relation to compensation, CHWs shared that their hours of work are impacted by the size of the population. The local community is often permanently settled in De Doorns, but the migrants move in and out based on agricultural employment seasons. Based on 2011 figures, the last official statistics from this area, an estimated 11, 000 migrants entered the area when the table grape season started every year, while the official (permanent) population is 10, 583 (Statistics South Africa, 2011). Hence, the migrant population significantly increases the overall population each year, meaning that when more migrants are in De Doorns, CHWs work more hours.

> *Time changes like from January to June is from 08h00 to 12h30, and from July to September hours last to15h30.*
>
> *Researcher: Why is it changing?*
>
> *I really don't know but I think is because when the season changes the hours changes also.*
>
> *Researcher: These hours have nothing to do with the population that is here?*
>
> *Yes it got to do with the population also. The more they are here the more the hours are extended and the less there are here the less we our hours.*
>
> *(56, Male, migrated from Lesotho, lives and works in Stofland, CHW, WS550094-95)*

Although CHWs reported working more hours, there was no mention of more CHWs being hired in those more demanding times. Along with this, Org B CHWs' restriction on offering services to illegal migrants also impacted the support that the migrant population received.

While the role of gender in this study was mentioned in an earlier chapter, it is important to raise it here as well, as the gender imbalance in the employment of CHWs posed a challenge in serving the population. At the time of this research, Org A had not employed any male CHWs, while Org B had one male CHW employed. Hence, the entire population in De Doorns was being served by one male CHW. During his interview, he identified the need for more male

CHWs so that those who did not feel comfortable reaching out to the female CHWs could also be served. However, compensation was a factor. He explained that CHWs are not well-paid positions, and as men in De Doorns attempted to support their families, the compensation served as a deterrent to more males being interested in the role.

Researcher: Most of the migrant men are willing to ask for help?

Yes.

Researcher: But local Xhosa and Sotho men are hesitant to ask...? Michael is the only male carer in De Doorns?

Yes.

Researcher: So Michael as the only male carer, what position does that that leave you in?

I don't have female patients, only male patients.

Researcher: How many years have you been a carer?

Since 2013.

Researcher: So the past three years as a carer and none of your patients have been female?

No.

He had, but they were transferred to me.

Researcher: Do you find you need more male carers in this community?

Yes we do because we have lot of male patient but at the same time man don't want to become carer because the money is not good.

(CHW FDG, WS550097)

Thus, it seems that male CHWs are particularly important, as female CHWs claimed that while the migrant men approached them for services, the local men would not approach them and

hence an important part of the population is left out.

> *Researcher: Although there are no migrants on your list, are you still working with migrants in health promotions that you do in the community?*
>
> *Yes a lot and I mostly ask about male circumcisions and I tell them where and what to do.*
>
> *Researcher: Are these local men or migrant men? Who gets circumcised most?*
>
> *I think [more] migrant men get circumcised than local. Because local men don't believe on circumcising at the clinic as is the tradition and as a woman I am not allowed to talk to men about circumcision. Only a man can talk to another man about that and we have reported that to the clinic and they know that.*
>
> *(Female, 39, Stofland, CHW, WS550092)*

In light of the various challenges migrants reported facing in accessing services, it is not surprising that an obstacle that CHWs reported facing is that not all migrants are eager to go to the clinic. This causes difficulty for CHWs because they are not able to force anyone, no matter their health condition.

> *We can't do anything besides encouraging them to go the clinic and by taking their medication as is for their own health.*
>
> *We can't also force them as they have rights to say we don't want to go to the clinic.*
>
> *Researcher: But we understand that they are not going because of the issues, long waiting, language issues, the appointment and the transport?*
>
> *Yes.*
>
> *(CHW FDG, WS550097)*

That said, CHWs stress continuing to do all that they can to encourage clinic use, and share the importance of continuing care and treatments.

7.4 MIGRANT PERCEPTIONS, INTERACTIONS AND EXPERIENCES WITH CHWS

The findings above presented the voices of CHWs. This section will present the migrants' perspectives on their experiences and interactions with CHWs, their expectations of what CHW roles are and/or need to be, and whether they perceived CHWs to play a role in their lives or not.

Overwhelmingly, the migrants in this study stated that they did not utilize the services of CHWs. While some said they did not reach out to one, most said a CHW had also never approached them. This quote represents one of many which shared the same thoughts. The migrants in the study also stated that they did not know exactly what the role of CHWs was.

> *At the moment I don't know them.*
>
> *Researcher: So you don't know the lady with health bags?*
>
> *Maybe they come at the time I will be at work.*
>
> *(Female, De Doorns, CHW, WS550111)*

However, once it was explained to respondents who the CHWs were and what their role was, all migrants in this study said that they would use CHWs if the need arose.

> *If my wife and I encounter health challenges, now that I know where she stay I would not take time to go to her for assistance, and to avoid getting to be questioned on why I took long to come and see what is wrong with you.*
>
> *(Male, 37, from Zimbabwe, lives in Stofland, WS550078)*

This suggests that information about the existence of CHWs has been limited for the migrants, and if more migrants were informed about the role of CHWs in the community, they would possibly use them.

As they were unclear on what CHW duties included, many migrants also suggested that CHWs should provide a wide range of services focused around assisting those who are in situations of poverty or immobile due to ill health, and who therefore cannot take basic care of themselves.

> *What they can do is that we have people who are sick and staying alone and they have no food so they can help by giving those people food or when a person can't help themselves so they must be able to help.*
>
> *Researcher: What do you think they (CHWs) can improve on? (Asked in Sotho)*
>
> *My comment is the same as that lady. There are people who are sick and can't afford to feed themselves so they must be able to go to those people and help to feed them.*
>
> *Another thing is that our job entails both woman and man and we both get sick. So when they find a woman sick they must be able to bath that woman and feed her if she really can't.*
>
> *(Migrant FDG, WS550098)*

As some quotes have shown, discussion with migrants revealed that many of their suggested duties for CHWs were in line with what CHWs claimed to already be involved in. For example, CHWs from Org A explained that they widely promoted the soup kitchen to all migrants who were not able to afford food due to being in situations of poverty.

> *Yes, and they will tell you that they don't want to take their medication and that they don't have food to take with the medication*
>
> *Researcher: And what happens then?*
>
> *There is a soup kitchen for everyone but still not all of them come to have a soup.*
>
> *More people are defaulting because they don't have food.*
>
> *(Female, 20, Smartytown (De Doorns), CHW, WS550093)*

Without food, the migrants had difficulty taking their medication, and CHWs felt that this poverty lead to migrants defaulting on their treatments, which impacted continuity of care negatively. However, the soup kitchen is not large enough to accommodate the large migrant population who required a meal, although some migrants benefitted from it.

Some migrants believed that CHWs are not necessary because the health facility they need is already accessible. Location is important to note in understanding access, particularly because no migrant in this study had their own transportation. Some migrants from Lubisi explained that the clinic was far from their home and they would need to take a taxi to reach it, which made their experience expensive. However, Stofland is located slightly closer to the clinic, and migrants living there stated that the location was not a problem for them.

> *I think here in Stofland there is no need because everything is there, just like the clinic is closer.*
>
> *(Male, 37, migrated from Zimbabwe, lives in Stofland, WS550078)*

The migrants who have had interactions with and assistance from CHWs shared the various roles provided by CHWs. One service provided was following up with patients for their missed appointment dates.

> *The CHW play their role like when you have missed you child appointment. They will come looking for you and ask why you have missed you appointment at the same time they will tell you to go for your appointment, so they work all around.*
>
> *(Migrant FDG, WS550100)*

> *If you have TB, the CHW will come everyday.*
>
> *Even at my crèche, they come to give that child TB medication.*
>
> *(Migrant FDG, WS550100)*

Another service which some migrants had taken advantage of is CHWs calling an ambulance for them in times of an emergency. As was discussed in an earlier Findings chapter, migrants stated that when they call for an ambulance, it took much longer than when someone local placed the call.

> *Yes I once needed their help by that lady when I had a TB; she called an ambulance for me. Because if an ambulance is called by them, it comes quickly than being called by me.*
>
> *(Male, 33, migrated from Free State, lives in De Doorns, WS550069)*

Overall, most migrants claimed to not have used CHWs, or not having a clear idea of what CHW roles were. Migrants who were told about CHW roles through the process of this study said they would reach out to a CHW going forward if needed, and some migrants who had used CHWs shared various services that are provided.

7.5 CASE STUDY

The case study presented below is intended to illustrate the experiences and interactions of a CHW, so that their roles, challenges and impact on the lives of migrants in De Doorns can be further understood. Of the 10 CHW individual interviews conducted, this was chosen because it included a range of experiences and issues which were also found in the other accounts. In order to respect confidentiality, the name Maria will be used for the case study.

Maria was a 29 year old female, born and raised in Stofland, De Doorns, which is one of the two sites of this study. She was employed by Org A, and explained taking the job to be able to help others. At the time of interview, she had worked as a CHW for nine years, primarily in Stofland,

and temporarily on a farm outside of Stofland.

> *I was approach by Org A people and ask if I wanted to be part of CHW. I then asked them what is CHW about and they explained to me and I was interested. The reason I took the job is because I love working with people and children and that I can speak three languages so with that I can help them with translation.*
>
> *(29, female, Stofland, CHW, WS550062)*

Her narratives provided a glimpse into the duties of CHWs, one of which has been translation services. Translating for migrants at the clinic was described by all CHWs as fundamental, as many migrants face language barriers.

> *Yes, I think we can have translators at the clinic...that is very important. Even though we have people who speak Xhosa but they are not translators and that sometimes delay the service at the clinic as they will doing their own job and that sister will go the chemist and get tablet for the patient without knowing what's going on with the patient.*
>
> *Researcher: So how are they prescribing the tablets if they don't know?*
>
> *Some do speak English, some they speak a bit of English as they didn't further their studies.*

Maria explained that CHWs like herself work as translators, and although it is not an official part of her job description she valued this as it has allowed her to interact with and better understand issues which migrants face.

> *What is good about it is that you get to communicate with the people in the community about their problem. Also because nurses are not able to communicate with the patient so we get to translate for them and also we take information from the clinic to the people as we cannot all be inside so there must be a person who takes out the information to the people.*

While she had made it a part of her work to promote awareness about health and clinic issues out in the community, she and other CHWs also did the same within the clinic.

We give talks at the clinic even though the job of the counselor (clinic staff, now CHWs like herself) but we sometimes sit in front and gives talks about almost everything.

Researcher: And what do the talks say to the people?

By encouraging them to take their medication and that AIDS does not kill - you kill yourself by not taking your treatment and by not accepting and must take care of yourself.

Maria expressed the need for more frequent and extensive training. While some training was provided to her periodically (every few years), and included topics which were directly relevant to her work, she wanted to learn more. Working with migrants was also included in that training, which benefitted her interactions with them.

I began my training in 2007; in 2010 I got training for mother to child transmission for three months. And have also received counseling training for three months to talk to people about everything and especially who are sick and do not want to go the clinic and migrants.

The majority of migrants on her patients list were from Lesotho and Zimbabwe, and a number of them were not legal. This illegal status caused an initial challenge, as the migrants did not feel comfortable reaching out to her. Due to their status, regardless of the fact that health services are constitutionally free for everyone on South African soil, they feared that government vehicles roaming in their areas could lead to their statuses being revealed and negative consequences following.

Yes, in my family I think I have more than five migrants from Lesotho. I am a care worker and as a careworker we have 15 families to take care of.

At first it was difficult but it got better as we go along. The reason is because they are scared of the government's car when they see one and that they are not used to this kind of life us living.

While CHWs are on foot and not in those government vehicles, they still shared the same roads and the communities are not large, meaning that the presence of government vehicles initially served as a deterrent to migrants approaching CHWs. However, this improved with time, as Maria and her colleagues gained the trust of people by speaking to them individually.

> *[they did not approach me initially]... because they don't have (legal) papers but we keep their file with Org A in Wellington which contains everyone details and problems.*

Maria mentioned the difficulties of working with illegal patients repeatedly, and she also shared how she coped with them.

> *The challenges is that they are people who live with fear from the police that they will depot them and fear from social worker thinking they will take their children away from them because we sometimes go their houses with social workers.*
>
> *Researcher: How do you deal with these challenges?*
>
> *By sitting down and explain to them the role of the social worker and that kind of a child that is taken away from the mother.*

Maria also emphasized the urgency in illegal migrants needing to apply for asylum papers, as there are many restrictions to their lives if they do not have some form of legal status.

> *Yoh! Yes, I would (like to help further) especially Lesotho children as they can't go to school because they don't have papers. Like one I know from Lesotho who grew up here has passed her metric but she can't get her certificate because she does not have papers.*
>
> *Researcher: So you can't get a high school diploma?*
>
> *Yes, she can only get the result statement.*

The quotes above demonstrated an example of not even being able to attend school without a legal ID, where even if one has gone to school and earned a diploma, that diploma will still not be awarded without proof of a legal status.

Maria also reported helping migrants with applying for legal papers, especially those who did not speak or understand Afrikaans, and confirmed that the migrant population was steadily increasing every year.

Alongside the challenges mentioned above, she brought to light other issues that the migrant community struggled with. The comment below highlights the depth of one challenging situation which Maria faced when carrying out her work in the community. It touches upon many issues, including those of child safety, violence, gender relations, power structures, vulnerability and health concerns arising from them. It also demonstrated that while she is a health worker, she had extended her duties to social welfare cases too. Issues of health are not isolated from other aspects of people's lives, but rather are interconnected.

Yes, it was with one of my migrant family from Lesotho.

I once went there alone and find a 5 year old baby lying on the bed and I asked what the matter with the child is? She replied by saying she has a fever and when I touch the baby I sensed there is more to the fever. After some days her neighbor told me that the boyfriend is raping the child and abusing the mother, when I went there to confront her, she was very scared and I had to tell her that I will get the police for her and she started to talk and tell me that her boyfriend is raping the child and even on my last visit he heard from people that I was there and hit her. I then took them to the victim protection ward in the police station and the police went to arrest him at work. The baby was taken to the hospital and the mother was taken to counseling, which both of them receive counseling for a year now. But now they are okay and both parents were HIV positive.

Researcher: And the baby...is she HIV-positive?

She was not but because of the rape from the father, she is now HIV positive.

Researcher: So in your role whenever you see something like this, you do all you can to protect them - so whether it be a health condition or social service?

Yes, I try all my best to help.

Maria also shared that TB, HIV and AIDS were the most common diseases, especially among young adults, in both the general and migrant populations, and described having worked with people living with those conditions. While her services did not include all that was required by the patients, she explained that her role was still important.

No, we don't give transport just information and food parcel for those who are not working, once a month.

Researcher: So your support for the migrants is mainly to provide information?
Yes and to also help them to accept themselves.

This research has confirmed that migrants are a large part of the De Doorns communities and require support with accessing health services. Maria explained her contributions, and emphasized the fact that intangible services, such as being patient and providing encouragement, made a difference to her migrant patients.

What makes it easier is the fact that I share love, show support and patience because most of them feel out-casted and at some point I make an example by myself as a I was diagnosed with HIV and AIDS 10 years ago before having my child. So sharing such information makes it easier for them to access the service.

Researcher: So the information you provide makes it easier for migrants to access the service?

I can say yes because they even come to my house to talk to me.

Maria also shared that the migrant populations she interacted with were well-informed about her role and duties, as well as those of other CHWs. She mentioned that migrants from Lesotho were most dominant in numbers on her list of patients, and that migrants referred others to her.

> *Researcher: Do you think the migrant populations know what role you play in the community?*
>
> *Yes, they know, especially migrants from Lesotho.*
>
> *Researcher: So that population is the one that you work with most?*
>
> *Yes, most of them are under [another organization]and when they have a migrant who have a similar problem they will refer them to me.*
>
> *Researcher: So they know who you are based on referrals?*
>
> *Yes.*
>
> *Researcher: And most migrants you see are from other countries or local?*
>
> *From other countries.*
>
> *They come to my house. Even those I don't know come to my house and when I ask how they know me the say they heard from other people.*

The quotes above show that when migrants felt safe to do so, they did reach out to CHWs. It also highlighted the demographics of the migrant population, showing that a large number of migrants in De Doorns were cross-border, rather than internal.

Maria's account also brought to light an underlying issue facing all migrant lives in De Doorns: that of poverty. This research repeatedly showed that despite some migrants living slightly better lives than in their countries of origin, where they had no employment or income, overall they were facing the harsh realities of a life entrenched in poverty. Her words showed that even basic necessities are lacking for many of them.

Clothes for the children. I wish we can have sponsors who can provide clothes for children here as they are really struggling for those and you will find a child with no shoes or one pair for the whole year to go to school.

Her words also touched on the importance of accessibility of services for migrants, in terms of location, catering to large numbers of patients, and clinic hours, and this emphasized the need for more CHWs and clinic staff, to accommodate the growing migrant population. Her experiences underlined some of the access challenges she and her colleagues face.

I think we should have more CHW because De Doorns is getting bigger. Are there, here and also at the hospice but still it is not enough. Because we have farmers and there are new houses, including old people who can't reach the clinic.

Researcher: Do you think the clinic is far from most of the people?

Yes. Or we can have a mobile clinic maybe twice a week or three times a week that will help a lot. If you can go behind that mountain you will see that there are lot of people there including old people.

Researcher: You don't find that people have been able to access the clinic enough?

I don't think so. They will be happy for it because especially when is raining you have to go the clinic with the baby or find that one is pushing one on the wheelchair.

I think what must change at the clinic is the date. Because the clinic is made for the people of Stofland and Lubisi and the surrounding area but as for the hours is okay because we have less staffs in the clinic with many people.

Researcher: So we need more staff in terms of the weekend or hours in the weekend?
Yes. During the week because during the weekend we call an ambulance which is not reliable.

(The ambulance is coming) from Worcester. Like this weekend we call it for this lady who was in labor so she ended up giving birth on the spot as it takes long to come. Think they are using one ambulance for us out of three ambulances in Worcester.

This case study was chosen as her challenges and experiences have been echoed by other CHWs too. Her words show that CHWs do interact with migrants, and that they have an important role to play in the well-being of both the migrant and local populations.

7.6 A SUMMARY OF FINDINGS

This chapter presented findings from CHWs in De Doorns, discussing their roles and experiences, including challenges they faced in providing services to the migrant population. It also included the experiences of migrants themselves, and presented their opinions of and interactions with CHWs.

The findings have been situated within Aday and Andersen's Framework on Access, which has five main components, and the findings of this chapter were best aligned in the category devoted to *characteristics of health delivery system*. While the framework focuses attention on components and processes related to health systems and access, the qualitative findings reported here show how these elements play out and intersect in real life, bringing the human dimension and context more fully into the analysis.

The chapter described how CHWs, who are frontline healthcare workers often living in the communities which they serve, are meant to facilitate entry into the health system for all community members. This includes the migrant population in the De Doorns context, who have explained facing numerous barriers to access.

CHWs reported interacting with and supporting the migrant population. Some claimed to support

migrant children more than adults, as the adults often worked on the farms for long hours each day, and left their children behind. When working with migrant adults, CHWs explained that they provide information and awareness, both in the clinic and out in the community, and provide translation services to migrants at the clinic. This was noteworthy because many migrants struggle with language barriers. In line with translation services, CHWs also explained that they assist migrants in filing for legal papers, as most are not literate in Afrikaans, the primary language that many official documents in the Western Cape use. The case study examined the experiences and challenges of one CHW in more depth.

However, migrants in this research overwhelmingly reported that they are not familiar with CHWs. For those who did know of them, many described not being fully knowledgeable on their exact roles, while others shared that they had never been approached by a CHW, or reached out to one. Some migrants stated that they did not need one. Of the ones who were familiar with CHWs and their roles, they shared the various services received. All migrants who were told about CHWs and their roles for the purpose of this study stated that they would approach a CHW in the future if required.

An explanation for this discrepancy in CHW and migrant accounts could be that there are not enough CHWs in proportion to the overall and growing population. Hence, while CHWs report supporting migrants, the numbers they have been able to support were likely fewer than those who required it. Therefore, a significant proportion of the migrant population, including the participants of this research, have stated not being familiar with CHWs since they had not yet had exposure to them.

The CHWs employed and working in De Doorns described concerns, such as lack of transport to reach patients living far from them, Org A CHWs being employed only part-time, and there not being enough CHWs to assist all those who need it. In Chapter 8 (Discussion and Recommendations), this issue will be further discussed and literature will be presented to better understand how CHWs working in limited numbers have been able to serve large populations in other locations. Based on other cases, relevant recommendations for De Doorns will be presented.

The findings presented here suggest that there are not enough CHWs, even though they play an important role in the community by supporting both migrants and locals to access health services, and by assisting with other health and social issues. In order to meet the needs of the growing population in De Doorns, more CHWs will have to be employed and trained; otherwise many migrants may continue to not benefit from valuable CHW assistance, which can improve their access to health services.

CHAPTER 8:
DISCUSSION, CONCLUSIONS, RECOMMENDATIONS AND CONTRIBUTIONS

8.0 INTRODUCTION

This final chapter begins with a summary and brief discussion of the main findings presented in the dissertation, and states the main conclusions arising from the study. Next, I discuss the findings in relation to the study's objectives, existing literature and relevant policies, including the first community survey of migrant access to healthcare in the area conducted by Kruger (2015), as his recommendations for further qualitative research were a major impetus for this study. Following a recapitulation of the overall conclusions of the study, recommendations for

program and policy initiatives and for future research are suggested. The chapter continues with a section presenting the study's original contributions, and concludes with a personal reflection on the experience of fieldwork and on the main themes which emerged from this qualitative study. A doctoral dissertation is an academic output, with the findings of the research needing to be conveyed in relation to the stated aim and objectives of the work, and situated within the chosen conceptual framework. However, what was equally important for me in presenting this body of work was to ensure that in the pursuit of understanding the health systems challenges, the voices and lives of the migrants would not be side-lined. The health system, and notably the many deterrents in access to care, must be understood within the context of migrant lives, not separately from it.

The aim of this study was to understand how agricultural migrants in the Cape Winelands District of Western Cape Province of South Africa navigate the country's healthcare system with respect to accessing healthcare services, which includes securing continuity of care, and the role of CHWs in this process. Thus, this study sought to identify and understand barriers to access to healthcare services for the migrant population in De Doorns. While Kruger (2015) reported that 83% of migrants in his study had used the local health services, his respondents also reported deep dissatisfaction with important aspects of access and quality of care (Kruger, 2015). This qualitative research therefore sought to explore these issues in more depth, focusing on how they have been addressed by migrants themselves, by the health services, and by community health workers. Thus, the study hopes to inform South African policy and practice regarding migrants' access to healthcare.

The chapters of this dissertation reported the perspectives of migrants, CHWs, health workers and managers on access to and continuity of care. However, it is important to stress that key determinants of access, continuity, and the lived experiences of healthcare lie outside of the health system and of health seeking behavior (Mackian *et al*., 2004; Cornally & McCarthy, 2011).

Lack of ID (passports and other legal documents) came up repeatedly as a barrier to access for migrants, as many who came into the country do not have IDs to provide. Along with this, most migrants survived very long and challenging trips to get to De Doorns, with some from Lesotho swimming across a river to avoid the border guards. Most used multiple types of transport, and some described being robbed at roadsides. Thus, many arrived at the end of their journeys having lost a lot of their belongings, including paperwork. The clinic requirement of producing IDs has led many migrants to present false IDs, which in turn has led to misdiagnosis issues. Hence, even if migrants are able to enter the system, the quality of care received is compromised.

Violence (including discrimination and fears of recurrent xenophobic violence) and poverty are two major determinants of health, and of initial and ongoing access to healthcare, permeating the narratives of migrants as well as CHWs, as discussed in Chapters 5, 7, and especially 6. These themes are interwoven throughout the many distinguishable factors and subthemes explored in this thesis. They affect both direct access to care (such as when ambulances took longer to arrive when a migrant placed a call, or when migrants faced a choice between seeking healthcare or being paid for a day's labor), and compound the risks to health from direct violence, constraints on movement for fear of violence, and the inability to afford adequate food and shelter.

Another important cross-cutting theme in the findings of this research was the agency of migrants in relation to their health. Regardless of the numerous and significant barriers to access which they faced, most of them still returned to the clinic when they felt that healthcare was necessary, or when they were advised to seek or continue clinical care. They continued to go, because they cared about their health, with a major factor being that they are in De Doorns for work, and they cannot work unless they are in good health. Hence, while health was not first on the list of priorities for most people, employment was, and this in turn made good health essential. This agency towards their health goes beyond healthcare, and is expressed in accounts underlining the importance of good nutrition, exercise, safe water, and housing.

These key themes highlight three overall conclusions: first, that the details of access (or non-access) matter and that specific barriers and facilitators must each be addressed; second, that these distinctive factors or "details" cannot be understood or addressed separately from each other and from determinants of health outside the control of migrants, health workers, or the health sector; and third, that migrants face barriers both similar to and distinct from those faced by the local population.

8.1 ENGAGING STUDY OBJECTIVES, LITERATURE AND RELEVANT POLICIES WITH STUDY FINDINGS

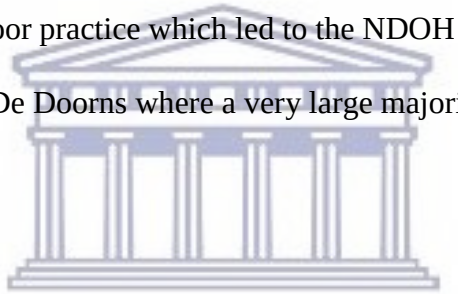
The first objective of this study was to document existing health sector policies and mechanisms that support access to and continuity of care for mobile populations in South Africa, in relation to international good practice, and this was done through the Scoping Review presented in Chapters 3 and 4. Chapter 3 discusses international good practice on the basis of the scoping review,

where 102 papers were reviewed and 42 were focused on due to their themes and issues aligning closely with the study objectives, while Chapter 4 presents the main legislation and policy guidance relevant to migrant access to healthcare in South Africa. The review identified research gaps in the existing literature, helped to understand recent migration trends, and the global context of migrants and their access to healthcare. Existing international policies and best practices such as the Interim Federal Health Program (IFHP) policy from the Government of Canada in 2006, the World Health Assembly Resolution on the Health of Migrants (61.17) in 2008, and the Migrant Health Guide were identified. The chapters also emphasized the need for more and better-quality research, both in South Africa and globally. Increasing co-operation between gatekeepers, providers, researchers and policy makers, and finding effective ways to reduce ambiguities in healthcare rights and obligations for undocumented migrants, is a challenge faced by most countries with migrant populations (Woodward, 2013). The ways in which the study findings reflect South African policy and international good practice will be discussed in the subsequent sections of this chapter.

Objective two was to explore and analyze how agricultural rural migrants in the Cape Winelands District accessed healthcare services. The related sub-objectives were to document care trajectories through which agricultural migrant workers have accessed (or not accessed) health services in De Doorns, and to explore facilitators and barriers to access as perceived by agricultural migrant workers, community health workers, facility staff, and managers.

The findings in this study overwhelmingly suggested that having a clinic near a population was not enough to ensure their access to services, as multiple barriers to access were reported by

migrants, most of which were confirmed by CHWs. These barriers persist despite the numerous documents and policies in place, such as The Constitution, The Refugee Act, National Department of Health (NDOH) Memo, National Department of Health Directive, Gauteng Department of Health Letter, and the HIV, AIDS and STI Strategic Plans. Each of these stated that migrants, regardless of their legal status, are allowed access to health services. While the intentions behind the documents and policies are admirable, the findings of this study have shown that the migrant population in De Doorns has continued to face multiple barriers to access, indicating a significant gap between policy and practice. In particular, the need to provide IDs to receive basic care from the clinic and from some CHWs is against government policy, and shows that the ambiguity and poor practice which led to the NDOH directives nearly a decade ago are still a concern, even in De Doorns where a very large majority of migrants do use the clinic at least once.



This study found that migrants were going to the clinic, supporting a major finding from Kruger's work, which showed the high utilization rates of the primary healthcare clinic in De Doorns with 83% of the participants having ever used it at least once (Kruger, 2015). However, the evidence presented here underlines that migrants face numerous barriers when attempting to access services once at the clinic. This often resulted in care that was not sufficient for their condition, and occasionally resulted in no care at all.

Migrants claimed that without possessing and showing legal ID documents at the clinic at the time of registration, they were not able to access services at the clinic, which was a finding established in Kruger's work (2015), and explored in depth in this study. As a strategy to access

services, some migrants resorted to using the ID of others. Sharing IDs has caused issues for the clinic staff, as it has led to misdiagnosing patients, and has also created issues in record management for them. Numerous authors have cited that a major barrier to migrants' access to healthcare was their legal status, and countries with high levels of migration should consider it their responsibility to create a healthcare system that allows every person to seek care efficiently, irrespective of his/her legal status (Hacker *et al*., 2015; Brock, 2015; Scholz, 2016).

The appointment system was cited by migrants as a major barrier to access. Introduced in 2014 in the Western Cape (and De Doorns) as a government initiative to deal with the notably long waiting times at health facilities, the system has not worked in De Doorns, at least from the perspective of users of health services. From their accounts, while appointments may work for chronic patients who are simply collecting medication, it does not work for other patients who require immediate service.

Both Kruger's and this study reported long wait times for patients, which impacted the migrant employment situation negatively. Kruger's work found that patients spent roughly 6 hours at the clinic (Kruger, 2015), while the current study confirmed that people are frustrated with long wait times, which deters them from seeking services because it causes them loss of income and difficulty with their employers at the farm, in a context where good relationships with employers are important to protect precarious employment. However, limited literature was found which discusses wait times. The few authors who have addressed the topic agreed with the study's findings that migrants face unusually long wait times when attempting to access services (FIDH, 2008; Amon & Todrys, 2009; Barnes, 2013).

Along with this, the majority of available articles, cited in this thesis, spoke about discrimination and almost complete lack of access. The focus of respondents on wait times and the appointment system rather than on total non-access is a new finding. It is important as it puts migrants in the same situation as South Africans and local residents, rather than setting them against each other.

Language barriers were also cited repeatedly as a deterrent to accessing services. The clinic staff primarily spoke Afrikaans and English, and while the migrants from Zimbabwe spoke English, others did not speak either of the languages used at the clinic. Migrants claimed that the staff told them to bring along a translator if they wanted services, and many were not comfortable with this demand, as health is a confidential matter, and they often do not want others from the community knowing their status. HIV, AIDS and TB affect a large portion of the migrant (and local) population, and there is still a level of associated stigma. Other authors (Lipson &Meleis, 1983; Neale *et al*., 2007; Chandler *et al*., 2012) have also indicated that while a common language is required in order for patients to express their concerns and for care givers to provide an adequate response, some understanding of each other's backgrounds and life context is also important, as these impact the kind of care that is provided and received. While the clinic responses do indicate recognition of the importance of a common language, these responses and the somewhat defensive insistence by some respondents that good services are provided to everyone suggest that staff are not yet integrating an understanding of and sensitivity to the cultural and life contexts of agricultural migrant workers in their practice. Being sensitive and responsive to the needs and realities of all patients – including migrants – does not mean having to be perfect, but does require openness to ongoing change and adaptation of healthcare practice.

However, at the same time facility staff from the De Doorns clinic shared their concerns about not being able to provide services to the growing migrant population, due to being short-staffed, and the clinic not being large enough to accommodate all patients. Kruger's work (2015) confirmed the same, and migrants and CHWs in this study echoed this concern. Due to minimal staffing, the clinic has not always had individuals who were able to translate for migrants during their visits. Short-staffing has also impacted waiting times negatively, causing frustration for patients as they waited long hours, missing most of their day at work and forfeiting pay. Through informal conversations, it was evident that locals have also faced the same issues with long waiting times and limited, and at times short-tempered, staff.

Another barrier which migrants mentioned was being denied certain operations due to their being high cost for the South African health system. While locals were able to get the same operations, migrants were told to go back to their own countries for them, which made them feel negative towards the system. As most were not able to travel back to their countries, and the availability and quality of services in their respective countries was often not comparable to that in South Africa, service denial based on cost caused challenges for migrants.

Distance to the clinic, transport to get there, and the hours of operation were also all cited as deterrents to access, which again supports Kruger's work (2015). Due to long working days, migrants required evening and weekend service, for which they needed to depend on ambulances from the neighboring town of Worcester, which is about 34km away. In South Africa, farm managers are required to provide decent housing on the farms for their resident workers, but this now represents only a minority of farm workers. In De Doorns, migrant farm workers are instead

transported to and from the farms daily. If they need the clinic during the day, which is when all appointments were scheduled as the clinic only operates till 4.30pm, they had to arrange and pay for private transport. This was expensive for them, and therefore has direct access implications, in addition to meaning that workers might have to forego a day's wages and risk making their employer unhappy about not having a worker that day.

The findings of this study thus support the conclusions of other published studies, and Kruger's Master's thesis upon which this research was initiated, which highlight the need to understand obstacles to of access to healthcare for different groups, such as migrants (Gruskin *et al*., 2007; Norredam, 2011; Kruger, 2015)

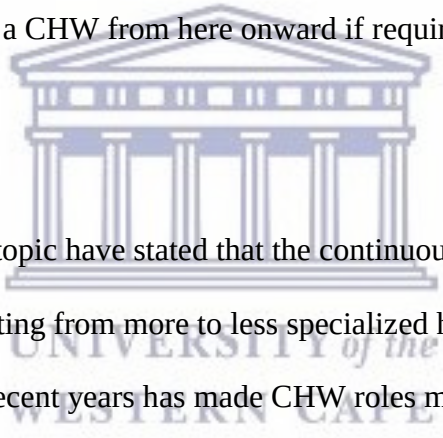
The third objective was to explore how agricultural rural migrants in the Cape Winelands District secured ongoing access, or continuity of care, across jurisdictions over time. A sub-objective included documenting care trajectories through which agricultural migrant workers have secured ongoing access/continuity of care in De Doorns, and exploring facilitators and barriers to ongoing access/continuity of care as perceived by agricultural migrant workers, community health workers, facility staff, and managers. The findings showed that transfer or referral letters were given to migrants as they left De Doorns, as a way to manage continuity of care for this mobile population. Some went home for the dry season, when they had no work on the farms, while others moved from one farm to another, based on seasons. No matter where they moved to, there were complications, as they easily defaulted on their treatments due to changing cities, countries and clinics. The transfer letter was meant to help manage the referral system better. However, the study has shown that many migrants lost them during their travels, while others

gave the letter to one clinic but then had no records to give to other clinics. Along with this, on average only two months medication was given at the De Doorns clinic. Sometimes migrants stayed away for longer, which led to defaulting.

Kruger's (2015) work reported that 40% of the migrant respondents who were mobile were not satisfied with the referral system, and the lack of communication between healthcare facilities, and this research has underlined the importance of developing a system where there is communication between health facilities in the locations where migrants travel to and from most, such as the Eastern Cape, and near the borders of Zimbabwe and Lesotho. While a referral letter is a well-intentioned and suitable idea to promote continuity of care, and it reflects intent to establish links between clinics and providers, this study did not show them to be entirely effective. A number of articles (Theyise, 2009; MSF, 2009; MSF, 2012; Hacker *et al*., 2015; Wild *et al*., 2017) have explained that cross-border collaborations are necessary to make progress against the global drivers of many health issues, such as TB. The ramifications of migrants struggling to use services include a risk to the overall public's health, especially when communicable diseases are involved, or a risk for more serious issues when health care is deferred (Hacker *et al*., 2015; Wild *et al*., 2017).

The final objective of the study was to explore the roles that community health workers (CHWs) played in facilitating access to healthcare services for agricultural migrant workers within the district and continuity of care across jurisdictions, as perceived by CHWs, agricultural migrant workers, health facility staff, and health sector managers. Limited literature on CHWs, and even less on CHW interactions with migrants, was found from the literature search and scoping

review findings; only 6 of the 104 included citations had any mention of CHWs. This research has therefore added original findings about the current and potential roles of CHWs in improving migrant access to healthcare. Contrary to what was hypothesized as a possible explanation of the high rates of clinic utilization reported by Kruger (2015), the participants of this study largely said they did not know who the CHWs were, and/or they had never used a CHW. As explained earlier, this may be due to the fact that migrant numbers outweighed CHWs heavily, meaning not everyone had exposure to them. However, the findings of this study show that the CHWs who did support migrants did so in ways beyond what was outlined in their job description. Along with this, all migrants who were told about CHWs and their roles for the purpose of this study stated that they would approach a CHW from here onward if required, indicating that they saw value in this role.



The majority of authors on this topic have stated that the continuous shortage of human resources for health, the need for task shifting from more to less specialized health workers and an increased burden of disease in recent years has made CHW roles more crucial and they have become community members who are also frontline healthcare professionals (Love *et al*., 1997; Chopra *et al*., 2008; Lewin *et al*., 2010; Perry *et al*., 2014; Oliver *et. al*., 2015). This aligns with the study's findings, which have shown that migrants do or feel that they would feel comfortable to discuss their health needs with CHWs, and are assisted by them both out in the community and inside the clinic through translation services.

The findings have shown that despite all the challenges listed above, migrants value health, are exercising agency, and doing their best to access services. While the barriers at the clinic are

numerous for them, they reported that they still go back because health matters. Health is a priority because they have come to De Doorns to make a living for themselves and their dependents, and without good health, they are not able to physically work. From this finding, it can be concluded that the barriers experienced by migrants, many of which were confirmed by the CHW and some by clinic staff, must be addressed individually and also collectively within the health system, to ensure that this large and vulnerable population is given the health services they require.

Many of the challenges reported in the literature are echoed in this study. In addition, the findings of this study show that in this setting, access to care is at least somewhat addressed by the health system, in partial alignment with the South African constitution and policy. The clinic and the health system do have mechanisms in place to try to enable access and continuity of care. Some translation by clinic staff and CHWs is available, referral letters are increasingly the norm, clinic staff and managers and hospital respondents are aware of migrants and migrants' needs, and some have even said they are responding well to these. Whether or not that is objectively the case is debatable, but the fact that the clinic staff has acknowledged migrant needs indicates at least some awareness of what should be done. However, these are not sufficient or optimized for local needs, including the multiplicity of languages, the concerns about confidentiality, and the limitations of paper-based referral letters for migrants who travel to and between multiple locations. They are even sometimes counterproductive, such as in the case of the appointment system which at one level is an attempt to treat everyone equally without discrimination against or in favor of migrants, but which according to migrants and CHWs does indeed treat people unequally. In some cases, such as requirements for official ID documents to receive services

from the clinic or from some CHWs, and refusal of care that is seen as costly, the study illustrates the barriers that government policy and directives are still trying to overcome.

8.2 LIMITATIONS OF THE STUDY

The design and methods used in this study have their limitations. During the data collection, saturation was reached. In other words, with the instruments used, by the current researcher of this study, given the ethical permissions which were granted, at that point in time, further research was unlikely to yield new information. However, sampling bias must be acknowledged. Had other cadres of health staff been sampled, such as Emergency Medical Services (EMS) phone attendants who answered the calls placed by migrants, ambulance drivers who transported them, and Worcester hospital frontline staff who worked closely with the migrants, other information important to the study could have been obtained. Also, people who were working on the farms may not have been fully involved. Data collection on farms (and with farm managers) might yield different or complementary results.

While this study's design included purposive sampling with a broad range of respondents, this was not fully possible due to the daily mobility of migrants to and from farms (by farm transport), and the multiple priorities of potential respondents which did not allow for them to commit to scheduled interview times. Hence convenience sampling, in addition to sequential referral sampling from multiple sources, was used more than initially envisaged. Possible implications of this may be that not all voices were equally heard and those who experienced barriers to access came forward to participate in this study, which they knew was focused on understanding challenges they had and continued to face. All findings presented should be interpreted in the knowledge that a different sample may have yieled different results. However,

the sample size for this study was large, and a wide range of voices – despite sampling method – were heard. Hence, conclusions drawn from the study and the recommendations made are robust.

Social desirability bias may have also impacted the findings of the study. It is possible that all groups of study participants – migrants, CHWs, clinic staff, and Department of Health managers may have answered some study questions in a way that was desirable yet not completely accurate, due to the fact that they were participating in a study with recorded responses.

Gender and other social characteristics of both the interviewer and the research participants may also have influenced the study. In line with most definitions, the WHO defines gender as "the socially constructed characteristics of women and men, such as norms, roles and relationships of and between groups of women and men" (WHO, 2017, www.who.int/gender-equity-rights/understanding/gender-definition/en/). These characteristics vary within and between societies and can change. Gender norms and roles influence people's susceptibility to different health conditions and diseases. This has an effect on their mental and physical health, and their overall wellbeing, as well as on people's access to and uptake of health services and on the health outcomes they experience throughout their lives (WHO, 2017). Hence, recognizing both the biological sex and the gender of the study participants (migrants, CHWs, clinic staff and department management) and the researcher was important to this research, and gender dimensions contributed to strengths and limitations of the study.

As the demographics of the sample have indicated, more female migrants participated in the study, and they were proportionately more represented in this sample than in Kruger's (2015) community-based survey.

> *The majority of respondents were female (59%) and 41% were male [and] this is not dissimilar to the profiles in Statistics South Africa's Census 2011 Community Profile Databases, which reported that 54% of people in De Doorns were female (n=2554) and 46% males (n=2213).*
>
> (Kruger, 2015:28)

Women also showed greater enthusiasm and interest in this study overall. As representation from males was low, it is acknowledged that more male voices may (or may not) have added different findings, as the experience of illness, migration, healthcare and health seeking behavior is gendered. However, the men in this study expressed similar challenges to those reported by women in regards to access to health services.

The gender of the primary researcher and the potential impact it may have had on study process and results is also worth noting. The primary researcher was female, aged 30 at initiation of the study, of South Asian descent, a Canadian citizen and English speaking. Not being able to speak the local languages of many participants has meant dependency on research assistants for communication, which has impacted the data collection process. While back translation is considered best practice in research conducted in multiple languages, it was not used in this study due to feasibility and cost constraints. However, random selections from various recordings were heard by a Social Scientist from the Medical Research Council of South Africa, who confirmed that the corresponding transcripts matched the recordings.

Though as an outsider the researcher brought different insights, being a foreigner has also meant less insight into local contextual issues than South African nationals. Reflexivity was extremely important for the primary researcher, given her positionality as an 'outsider' who spent a lot of time in the communities, interacting with migrants and locals on a regular basis for the months of fieldwork, and on many days feeling like an 'insider.' She also engaged regularly in peer debriefing with the study's RAs and research colleagues, and the data was triangulated through a number of methods to add to the credibility of the work.

The findings reported in this thesis must also be interpreted in light of how gender, race, nationality, age, social class and other attributes may have affected who participated or did not participate in the study, and how. While attention has been given to the ways in which gender influences the collection and analysis of qualitative data, most of this has been focused on qualitative interviews, primarily with women and the influence of the interviewer as female in this specific context (Broom *et al*., 2009). In contrast, less work has been reported on comparing different interviewer–interviewee contexts: male to female, male to male, or even female to male interviewing has not been widely researched (Ibid). Based on the context of De Doorns and the conversations with the population there, it is likely that a female researcher (and female research assistant accompanying her) may have attracted more female participants, who felt a sense of security in sharing their lives with her. The male participants may have been few because they did not feel the same sense of comfort.

Along with this, the data collected from interviews with the CHWs indicated that the local men in De Doorns did not freely share personal health-related matters with females (male CHW, born in Lesotho, lives in Stofland, WS550094-95). As this research was focused on access to health

services and understanding people's health experiences, the topic may not have been of interest for them to discuss with a female researcher, or it may not have been a priority or area of interest to them, regardless of the researcher's gender. However, in order to fully understand the influence of a researcher's gender on the study, it is important that attention be given to the complex inter-sectionality of gender and other factors such as psycho-social and environmental ones; these factors are essential to consider in qualitative data analysis and write-up (Broom *et al*., 2009).

The gender of CHWs, the De Doorns clinic staff, and the provincial and district management who participated in this research is also important to state. At the time of the study, there was only one male CHW employed in De Doorns, referenced above. The gender imbalance was discussed in an interview with him, and he shared the need for more males in this work to support the De Doorns population. Of the clinic staff interviewed, one was male. Of the management interviewed, one was male.

Overall, female participants outnumbered males in this research, despite efforts to reach out to males in De Doorns and to gain their interest in the study. The findings reported in the following chapters speak to both men's and women's experiences, but must be interpreted in light of the demographics of the respondents who participated in the study. Beyond what has been addressed here, there is a large and growing literature on gender and health. A deeper analysis, which was not the aim of this thesis, will be considered for future publications.

8.3 OVERALL CONCLUSIONS

This study sought to understand how agricultural migrants in the Cape Winelands District of Western Cape Province of South Africa navigate the country's healthcare system in terms of accessing healthcare services, including securing continuity of care, and in particular the role of CHWs in this process, with the aim of informing policy and practice. The perspectives of migrants, CHWs, health workers and managers on access to and continuity of care have been reported. Most of the barriers to access cited in the existing international and South African literature are present in De Doorns, despite the efforts of the clinic to try to meet some migrant needs, and despite efforts to access healthcare reported by migrants here and in earlier work in this setting (Kruger, 2015). However, there has been little focus in the past on the roles and contributions of CHWs as active intermediaries with an understanding of and sensitivity to the migrant community, the local community and the health system, and this research therefore addresses the gap to some extent. Even though most of the migrants who participated in this study did not interact directly with CHWs or even know about them, the findings show that CHWs can and do actively contribute to effective access to healthcare and to the determinants of health among migrants, and that migrants are receptive to further developing this relationship.

However, key determinants of access, continuity, and the lived experiences of healthcare lie outside of the health system and of "health seeking behavior", including discrimination based on nationality and lack of ID documents, pervasive violence, poverty, and precarious employment, while the determination and agency of migrants to survive and be healthy were positive determinants of access.

Three overall conclusions can be drawn from this research. First, the details of access (or non-access) in a specific context matter, and these specific barriers and facilitators must each be addressed. Second, these distinctive factors or "details", some of which are specific to the De Doorns context, but many of which have been reported in other contexts in South Africa and around the world, cannot be understood or addressed separately from each other and from determinants of health outside the control of migrants, health workers, or the health sector. Third, migrants face barriers both similar to and distinct from those faced by the local population.

The recommendations and conclusions arising from this research are made in the hope of contributing to addressing these challenges in ways that will improve access to and continuity of care for migrants in De Doorns, as these migrants are an integral part of the life, economy and health of the overall community.

8.4 RECOMMENDATIONS FOR FUTURE POLICY AND RESEARCH INITIATIVES

The findings in this study suggested numerous areas where attention is deserved, and the following recommendations are being made for policy and program initiatives:

1. This qualitative study was situated in De Doorns, in the Western Cape, but it is important that similar qualitative studies be carried out in other parts of the country, where the migrant population is also significant. A comparison of findings from various settings will assist in better understanding the barriers, because if certain barriers are faced by all migrants across the country, then national policies and programs can be designed to address them. For issues which are context-specific, a different set of locally-specific action will need to be taken.

2. This study has shown language to be a significant barrier for migrants in being able to access services. It is essential that a program or policy be put in place in the Western Cape (and other provinces as needed) to ensure that no patient's access to care or quality of care is hindered because staff cannot communicate with them. The data shows that the main migrant languages in De Doorns are Sotho and Xhosa, and it is recommended that a staff member with fluency in one or more of those languages be available at all times.

3. Long waiting times were reported as a source of overwhelming frustration for the migrant population, and while locals were not interviewed as a part of this study, general observations have shown that they also faced challenges with this. The appointment system was put in place to assist with this issue, but the findings have shown that it has not achieved its desired goal. It is recommended that either the appointment system be re-assessed and designed in a way that it caters to patient needs, or a policy be created and carefully implemented where wait times are reduced and patients are given an appointment on their first visit. While they may be given an appointment to return for a follow-up, the findings have shown that migrants need to be seen on their first visit. Their health is tied to their capacity to work on the farms, and accessing services immediately is imperative.

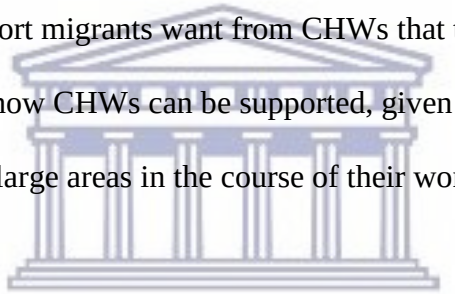
4. Migrants highlighted the barrier faced when they did not have legal ID documents to show at the clinic. It is understandable that an ID verifying a person is necessary at the clinic for their records, and to create a file. However, as migrants have experienced difficulty obtaining IDs, it is recommended that a program be put in place where a

government official is present at the clinic to make IDs for them. This way, they can receive an ID and be provided with service at the same time.

5. Clinic location and hours were mentioned as a barrier to accessing services. As no migrant in this study owned transport, they struggled to leave work during the day to visit the clinic. It is therefore recommended that a policy be put in place which allows clinics to operate longer hours so migrants can schedule their visits after the farm trucks have brought them back to De Doorns. Also, if resources can be allocated, it would be ideal to have emergency services available at the De Doorns clinic 24 hours a day during the months where farms are in full operation for grape season, and migrant numbers are largest.

6. Transfer letters were given to migrants when they left De Doorns. While the focus on planning for a mobile population by the DOH is commendable, it has not shown the desired results. It is recommended that if a paper-based system is necessary, it be in the form of documents that the patient retains, rather than a letter to be given to the next facility. However, given the challenging physical conditions in which migrants live, work and travel, any paper-based system risks being problematic. This study therefore supports further work on how an electronic referral system may be developed for all patients (migrants and locals). In addition, it is recommended that relationships be built with the most frequently-utilized health facilities in the locations neighboring the district, the province, and across the South African border, so that patient files can be shared electronically, and mobile populations are not burdened with the full responsibility for continuing their care during their frequent travels.

7. This study also focused on the role of CHWs in helping migrants to access health services. It underlines the importance of work in South Africa on re-engineering primary healthcare, and specifically on the many roles of CHWs in the health system. Ongoing monitoring and evaluation, and further qualitative research is needed to understand the role of CHWs in other parts of the Western Cape, to assess how their official roles may need to evolve or be changed, and to ensure that their compensation, work conditions, and support structures are adequate to allow them to maximize their full potential. In communities with high migrant populations, exploring ways to create stronger CHW-migrant linkages may strengthen care for this vulnerable population. Recommended research can look at how many migrants one CHW can care for, what types of support migrants want from CHWs that they cannot or will not get from the clinic and logistically how CHWs can be supported, given that they typically do not own vehicles but need to cover large areas in the course of their work.



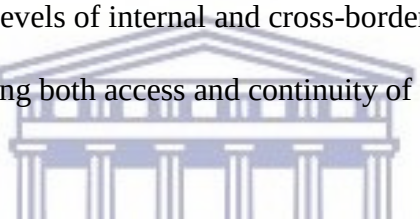
While the recommendations provided above are focused on the migrant population, addressing them will also benefit the overall access to care for all patients. Some issues may be unique to migrants, but others impact everyone using the health system.

If research is to be conducted for policy purposes, it is recommended that the methodology of in-depth interviews and focus groups be used. While all the methods utilized for triangulation purposes were helpful, those two provided data which contained the most detail, and allowed an opportunity for one-on-one conversations to understand the issues from the perspectives of the participants. The focus groups allowed conversation between people where issues heard in the

individual interviews were validated. For policy purposes, this can confirm the need for and direction of certain policies in a timely, scientifically sound and cost-effective way.

8.5 CONTRIBUTIONS OF THIS STUDY

This study has contributed to the body of empirical evidence in this field. There is very limited research evidence and almost no published evidence about this area of the Western Cape (De Doorns), where a large migrant population is situated. The findings of this study may therefore contribute to district, provincial and national planning for more inclusive health services, responding to the reality of high levels of internal and cross-border migration in a context of acute and chronic disease, requiring both access and continuity of care.



This study, through various methods of triangulation, showed the stated realities of migrants, and highlighted how the health system works. It presented data which outlined barriers to access for migrants, which have been documented in previous research, although not from any study situated in De Doorns or the Western Cape.

While it is not an original contribution of this thesis to identify language barriers and the other listed challenges, as other authors have identified and published on these issues, this work is an original contribution in a number of areas, including the following:

1. Health, wealth and migration are uneven, and differently experienced and managed across South Africa and elsewhere. It is important to collect and understand empirical evidence on the diversity of experiences without necessarily generalizing from one experience to the

whole world. However, there are also common themes. This study has provided an empirical qualitative study which also builds on and complements recent quantitative work.

2. Most of the existing publications cited in this dissertation related to migrant access to care and to xenophobia and discrimination deal with Gauteng. The Western Cape is different from Gauteng, in its economy, its proximity or distance from other provinces and countries, and its health system and political context. De Doorns is different from the major metropolitan areas of the Western Cape, but may be more similar to other agricultural areas with patterns of circular migration. Hence, the findings of this study may inform research, policy and practice affecting other similar communities in the Western Cape and elsewhere.

3. This thesis sheds light on and adds detail to many of the issues which James Kruger identified in his study (2015), without arguing that the situation is hopeless. As noted, while 83% of respondents in Kruger's study reported that they had "used" the clinic in some way, this did not always represent good, adequate or sustained access to decent care. In fact, many times people "used" the clinic, but left before even being seen. While Kruger also reported many of the migrant concerns found in this study, they may be less visible in his work, meaning that an overly-positive picture may have been painted. On the other hand, this thesis in combination with his work shows that there is both room and hope for improvement – including with the active cooperation of migrants themselves.

4. The role of CHWs in actually and potentially facilitating access for migrants is an original contribution of this thesis. While the study hypothesized that CHWs likely played a big

role in connecting migrants to services, thus helping to explain the very high utilization rates reported by Kruger (2015), the migrant participants of this study largely stated that they did not know who the CHWs were, and/or they had never used them. This may be explained by the fact that the numbers of CHWs in the community are small compared to the large migrant population, but it remains a finding that has not been published previously.

On the other hand, this study has shown that while CHWs are in some ways neither community members nor health workers, they actually are intermediaries between communities and health services, know and understand community and migrant realities and concerns, and contribute to facilitating access to and continuity of care. Even though they are not currently well known or used by migrants in De Doorns (and likely other areas with large populations), this study suggests that they can and could play important and valued roles.

5. The study has shown that it is important to understand the extent and ways in which health system and clinic factors intersect with and are interwoven with major structural and social determinants of health. These include pervasive violence, poverty and livelihood concerns, and the more subtle discrimination, and perceived and real xenophobia reported by nearly all respondents, including CHWs. The story of the De Doorns population is not a simple one where two sides (a good and a bad) exist, nor can it neatly be categorized into "factors" in a technical framework addressing access to care.

6. This work complements the migration focused and framed work of other scholars and activists, bringing it closer to the ways in which frontline workers, CHWs, local health managers,

and policy makers might experience and see things, highlighting some of the divergent experiences and perspectives of migrants, CHWs, and staff in ways that will hopefully contribute to engagement and dialogue, rather than the more confrontational work seen from some activist-researchers. This dissertation echoes and further strengthens many of the findings and conclusions of a growing body of work, while also contributing confirmatory evidence from a new site and population, and providing complementary evidence to quantitative work. It also adds complementary evidence to migration-focused work, with a study that was close to the ground, and sought to engage with and hear migrants' experiences of the South African health system.

8.6 PERSONAL NARRATIVE: REFLECTIONS ON FIELDWORK AND KEY EMERGING THEMES

I conclude this thesis with a personal reflection on the fieldwork and key themes emerging from this study. As I reflect back to the start of my fieldwork in 2016, I still recall my first interaction with a migrant in De Doorns. I had driven to my Research Assistant's house to pick her up, and together we drove back to the De Doorns clinic. She was there earlier in the day, and had spoken to a few migrant patients about doing an interview with us. As I parked, she went inside to look for the people who had earlier agreed to speak to us. I got out of the car to wait for her, and looked at the huge queue of patients waiting to get inside the clinic. I wondered if this was the norm, or if something had gotten all these people ill at once.

A woman smiling at me caught my eye. She was carrying a beautiful baby boy. I went to greet her, hoping we would be able to communicate. She was from Zimbabwe and spoke English, and

I asked how long she had been waiting. She said it had been hours, and her baby was very hungry. I asked if she could go home and return later in the day. She explained that she had already lost her day of pay at the farm, and it was her "appointment day", so she would rather wait instead of losing what little chance she had of seeing the doctor. She told me there were times when she would wait the entire day and still not get help, because too many people were ahead of her at closing time, and the staff were not organized enough to cope. She pointed at the huge queue and shared how in the years she had been here, the migrant population was only getting larger and the clinic was not big enough. There was not enough staff, she added.

As I was holding her baby in my arms and listening to her share her frustrations, my Research Assistant came outside with an upset look. She said the people whom she had spoken to earlier, and who had committed to interviews today, were no longer inside, meaning that we would now have to make another plan on how to recruit participants for the day's interviews. I said goodbye to the woman and her baby, and left with worried thoughts of how to get my fieldwork 'started.'

We drove around the towns of Stofland and Lubisi, this study's fieldwork sites, and managed to find a few other migrants who agreed to do pilot interviews with us. It was not until late that night as I was lying in bed that I realized my fieldwork had begun not with my first 'consented, recorded' interview, but rather with the woman at the clinic that morning. I did not understand this at the time, but in the few minutes with her, I was exposed to many of the pivotal issues which would come through in my following months of data collection and data analysis.

Months of fieldwork followed that first day. Some days were exciting, some frustrating, some confusing, some satisfying, some disappointing; not a day passed when I did not learn something new, whether it was about the research content, context or process.

I undertook a qualitative public health study, for which I carried out in-depth interviews and focus groups with migrants and CHWs, care trajectory interviews with migrants, in-depth interviews with clinic staff, hospital managers, and head of departments in the health sector, and participant observations with CHWs (as I went along on their workday). I formulated interview questions which were relevant and appropriate for the population, and aligned with my research objectives. I piloted them first to receive feedback, revised questions whenever needed, and worked closely with my supervisors and colleagues to make sure I was doing things 'right.'

However, as I look back at those 3.5 months and try to recall the moments of my most prominent learning, it was usually not the hundreds of hours of interviewing with a recorder in front of me, furiously taking notes at the same time (to not miss a single detail!). It was the times in-between, as I was walking down the unpaved roads of Stofland and Lubisi with women from the community who had just gotten off the big trucks transporting them back from their farms after a long day. It was sitting on crates of beer on Friday nights, chatting with the farm worker men about their week. People got paid on Fridays, and alcohol use became excessive in both communities from Friday afternoon into the weekend; drinking was seen to be a part of the men's socializing process. It was standing outside the clinic having casual conversations while migrants were waiting for their turn, sitting on a rock on the ground watching kids play ball as the parents shared their frustrations, while we laughed and complained about the hot weather.

As a qualitative researcher, we are trained to observe our surroundings, the context, and the "unsaid" things. It is meant to add to the work. It did not take me long to realize that the "unsaid" things and simply being in and a part of the communities added a tremendous amount to the study, and to me on a personal level.

In 2013, when I engaged in research documenting migrant lives for the first time (in various parts of the Western Cape), what attracted me most to that work was the phenomenal resilience which migrants showed. No matter what adversities they went through (poverty, xenophobia, unemployment, terrible living conditions, health challenges, and many others), they were still strongly determined to succeed in their new lives in South Africa. Even when it seemed natural for most to give up, they did not. I have found that same strong thread of resilience among the migrants in De Doorns, in all aspects of their lives, including their determination to access health services despite the many obstacles which this dissertation has documented.

This thesis had explicit hopes to inform South African policy and practice regarding migrants' access to healthcare. During the fieldwork period, as the staff and managers were busy and did not see the immediate added value of the study to Kruger's preceeding work, a more participatory approach involving them in dialogue and co-desinging solutions was desired but did not actualize. The findings of this study have since shown how this research has built on Kruger's work in important ways.

Even as the Doctoral journey nears a conlusion for me, I remain committed to going back to De Doorns to convene migrants, CHWs, clinic staff and Department of Health officials to provide

feedback sessions on the findings of this research and as importantly, to co-design elements of an action plan to move the work forward.

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APPENDICES

APPENDIX 1: ETHICS CLEARANCE, PERMISSION LETTERS, PARTICIPANT INFORMATION SHEETS AND CONSENT FORMS

UWC ETHICS CLEARANCE LETTER

UNIVERSITY of the WESTERN CAPE

DEPARTMENT OF RESEARCH DEVELOPMENT

18 January 2016

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms N Jalal (School of Public Health)

Research Project:	Agricultural migrant workers navigating the health system: Access, continuity of care and the role of Community Health Workers in De Doorns, Western Cape.
Registration no:	15/7/12

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
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Western Cape Government
Health

Worcester Hospital
Human Resource Development
Enquiries: Ms RR Ahmed-Meyson
Tel: 023 348 6405

Dr Nafeesa Jalal

Reg Nr: 15/7/12

Research Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the role of the Community Health Workers in De Doorns, Western Cape.

Your request for access to Worcester Hospital has reference.

We hereby advise you to contact Dr A Wenteler on 023 348 1225, for access from De Doorns to Worcester Hospital and referral out to community health workers.

With regard to Emergency Medical Services, contact Dr S de Vries for EMS information on 021 932 1966.

This study is focusing on Primary Health Care and NOT general specialist services.

Best Wishes

MS E VOSLOO
CHIEF EXECUTIVE OFFICER
DATE: 25/4/2016

Murray Street, Worcester, 6850
tel: +27 23 348 6405

PO Box 3058, Worcester, 6849
Roshen.Ahmed-Meyson@westerncape.gov.za

PARTICIPANT INFORMATION SHEETS (ENGLISH, AFRIKAANS, XHOSA/ZULU AND SOTHO)

UNIVERSITY OF THE WESTERN CAPE

PRIVATE BAG X 17, BELLVILLE 7535, SOUTH AFRICA

Tel: +27 21-959 2809 Fax: 27 21-959 2872

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Revised: September 2014

INFORMATION SHEET

Project Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

What is this study about?

This is a research project being conducted by PhD candidate Nafeesa Jalal at the University of the Western Cape. We are inviting you to participate in this research project because we want to learn how migrant agricultural workers get access to health care. We want to learn about the experiences and opinions of people like yourself who are: working adults (18 years of age or over), new or longstanding migrants either from South Africa or another country; those who have language barriers and those who do not, people who have reported using services, and those who have not used services; community health workers working in Lubisi or Stofland, and health workers and managers involved with the health care of agricultural migrant workers and with CHWs. The purpose of this research project is to understand how agricultural migrants in the Cape Winelands District of Western Cape Province of South Africa navigate the healthcare system of S.A. with respect to accessing healthcare services including securing continuity of care, and in particular the role of Community Health Workers in this process, in order to inform policy and practice.

What will I be asked to do if I agree to participate?

You will be asked to participate in in-depth discussions and group discussions called Focused Group Discussions. If you are a Community Health Worker (CHW), we will also be shadowing your work day in Phase 3 of this study.

The location for this study will be in the communities of Lubisi and Stofland in De Doorns, in the Western Cape. Each interview will be approximately 1-2 hours in duration. The overall duration of the study will be approximately 3 months in total.

The type of questions asked of the migrants and CHWs will revolve around their experiences with healthcare services, and the part they play in providing those healthcare services; respectively. Health sector employees, managers and staff of the healthcare facility will be asked questions revolving around their roles as providers and their experiences in their interactions with migrants.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure your anonymity, you will be assigned a unique ID so that your name and identity will be kept anonymous. There will be an identification key, the researcher will use to link your interview to your identity and only the researcher will have access to this identification key .

To ensure your confidentiality, only identification codes will be used on all data forms that are to be used, the information will be secured in a locked storage space and any data in the computer files will be password protected. If we write a report or article about this research project, your identity will be protected.

This study will use focus groups therefore the extent to which your identity will remain confidential is dependent on participants' in the Focus Group maintaining confidentiality.

What are the risks of this research?

There may be some risks from participating in this research study.

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

In-depth interviews will be time consuming and may cause some fatigue and hence, we will be providing light refreshments to the participants.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about migrants' healthcare access and continuity of care for those migrants. We hope that, in the future, other people might benefit from this study through improved understanding of how to navigate through the healthcare system in order to obtain better healthcare and better continuity of care.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you

decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by **Nafeesa Jalal, Department of Public Health** at the **University of the Western Cape**. If you have any questions about the research study itself, please contact Nafeesa Jalal at:

5305- 60 Absolute Avenue, Mississauga, ON L4Z 0A9, Canada; Tel: 1-416-857-5273; Email: nafeesajalal1@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Helen Schneider

School of Public Health

Head of Department

University of the Western Cape

Private Bag X17

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Prof José Frantz

Dean of the Faculty of Community and Health Sciences

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This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: *to be inserted on receipt thereof from SR*)

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Revised: September 2014

Inligtingsblad

Titel van navorsing projek: Landbou migrerende navigeer die gesondheid stelsel: toegang, kontinuiteit van sorg en die rol van die gemeenskap gesondheidwerkers in De Doorns, Wes-Kaap.

Waaroor gaan die studie?

Die studie word gedoen deur PhD kandidaat Nafeesa Jalal van die Universiteit van di Wes-Kaap. Ons nooi u uit om deel van die studie te wees sodat ons kan leer hoe landbou werkers toegang kry vir gesondheidsorg. Ons wil leer van mense wat:

- Werkende volwassenes is (18 jaar en ouer)

- is migrerende van enige land (Suid Afrika of ‘n ander land)

- migrerende wat taal hindernesse ervaar

- migrerende wat gesondheidsorgdienste gebruik en van hul wat dit nie gebruik nie

- Gemeenskap gesondheidsorgwerkers wat in Lubisi en Stofland werk, ander gesondheidwerkers, en gesondheid bestuurders wat met die gemeenskap gesondheidsorg en gesondheid werkers werk

Die doel van die studie is om te verstaan hoe landbou migrerende in die Suid Afrikaanse Kaapse Wynland Distrik die gesondheidsorg stelsel van Suid Afrika navigeer spesifiek aan beveiling van kontinuiteit van sorg, en die rol van gemeenskap gesondheidsorgwerkers in die proses, om beleid te beinvloed en implementeer.

Wat moet ek doen as ek deel neem?

U sal gevra word om in ‘n individuele in-diepte onderhoud deel te neem sowel as een groepbespreking wat ‘n “Fokusgroep” genoem is. As u ‘n gemeenskap gesondheidsorgwerker is dan sal ons u vir een dag rond volg terwyl u werk. Dit gaan plaas vind in fase 3).

Die studie gaan in Stofland en Lubisi, de Doorns, Weskaap plaasvind. Elke onderhoud sal ongeveer 1-2 ure vat, en elke fokusgroep gaan ongeveer 2 ure vat. Die hele studie sal oor 3 maande plaasvind.

Die tiepe vrae wat ons vir die migrerende en gesondheidsorgwerkers sal vra is oor die ervaaring met gesondheidsorgdienste en hoe die gesondheidsorgwerkers die diens voorsien. Ander gesondheidwerkers en bestuurders van fasiliteite sal gevra wees oor hul rol as verskaffers en ook hul ervaaring in hul interaksies met die migrerende.

Sal my deelname aan hierdie studie vertroulik gehou word?

Die navorsers gaan u identiteit veilig hou deur u ‘n nommer te gee in plaas van u naame te gebruik. Die navorsers sal die spesifieke nommer op al u dokumentaasies aansit.

Om u vertroulikheid te hou, al die dokumentasie sal opgesluit wees in ‘n stoorplek, en al die data in ‘n PC gestoor wees met ‘n wagwoord. As ons ‘n artikel skryf oor die navorsing, sal u identiteit beskerm wees.

Omdat ons fokusgroepe is net aan die tweede fase van die studie, die vertroulikheid van die informasie wat gesprek is sal op u self en die ander deelnemers van die fokusgroep rus.

Wat is die risiko van die navorsing?

Daar kan dalk risiko wees om deel van in die studie te neem. Menslike interaksie en as ‘n mens oor hul self of ander mense praat dra ‘n bietjie risiko. Ons sal ons beste probeer om die risiko te verminder en u stiptelik help as u enige ongemak deur die studie voel. Wanneer dit nodig is, ons sal u ‘n toepaslike verwysing gee om ‘n professionele te sien.

Die individuele onderhoude en fokusgroepe sal tyd vat wat kan vir u moeg maak. In lig van die, ons sal iets klein gee om te eet en drink.

Wat is die voordele om in die studie deel te neem?

Die navorsing is nie bedoel om u persoonlike te help nie, maar die resaltaate mag die ondersoeker help om meer van die migrerende se toegang na gesondheidsorgdiens te leer. In die toekoms, ander migrerende kan voordeel van die navorsing deur beter verstand van hoe om die gesondheidsorg stelsel te navigeer om beter gesondheid en kontinuiteit van sorg te kry

Moet ek in die navorsing deel neem en kan ek ophou as ek wil?

U saam deel in die navorsing is uit u eie wil. U kan besluit om nie deel te neem nie. As u besluit om deel te neem, dan kan u op enige tyd ophou. As u kies om nie deel te neem nie, of as jy deel neem en dan besluit om nie deel te neem nie, sal u nie op enige manier gestraf word nie, of enige voordele van u weg gevat wees nie vir wat jy voor kwalifiseer.

Wat as ek vrae het?
Die navorsing is deur Nafeesa Jalaal gedoen. Sy is van die Department van Publiek Gesondheid vanaf die Universiteit van die Wes-Kaap. As u enige vrae het oor die navorsing studie, kontak aseblief vir Nafeesa Jalaal by:

5305- 60 Absolute Avenue, Mississauga, ON L4Z 0A9, Canada; Tel: 1-416-857-5273;

Email: nafeesajalal1@gmail.com

As u enige vrae het oor die studie en u regte as iemand wat deel neem in die navorsing, of as u enige probleme ontvang het verwant aan die studie, kontak aseblief:

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Die navorsing is goedgekeur deur die Universiteit van die Wes-Kaap;s Senaat navorsingkomitee. (REFERENCE NUMBER: *to be inserted on receipt thereof from SR*)

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Revised: September 2014

IPHEPHA LEKCUKACHA

ISIHLOKO SALEPROJECTHI: Abasebenzi bezolimo abangabafiki bazama ukumelana nenkqubo yezempilo ukufukeleleka ukuqhuba kononophelo kunye nendima yooNompilo e De Doorns eNtshona Koloni

Ingaba esisifundo singantoni?

Olu luphando olwenziwa ngumfundi wezobugqirha(Phd) u Nafeesa Jalal kwi dyunivesithi yeNtshona Koloni. Siyakumema ukuba uthathe inxaxheba koluphando ngokuba sifuna ukufunda ukuba abafiki abangabasebenzi kwezolimo bafikelela njani kwezempilo. Sifuna ukufunda malunga nolwazi nemibono yabantu abanjengawe: abasebenzayo abadala (18 yeminyaka nangaphezulu), abafiki abatsha okanye ekudala bafika besuka eMzantsi Afrika okanye kwelinye ilizwe; abo banezithintelo zolwimi kunye nabo bangenazo; abantu abasebenzisa iinkonzo kunye nabo abangasebenzisi nkonzo; oonompilo basekuhlaleni abasebenza e Lubisi okanye e Stofland, noonompilo basekuhlaleni kunye naphathi ababandakanyeka kwezempilo zabasebenzi bezolimo abangabafiki kunye noonompilo basekuhlaleni. Injongo yoluphando kukuqonda indlela abalimi abangabafiki kwi Cape Winelands District zephondo leNtshona Koloni ku Mzantsi Africa abafumana ngayo amajelo ezempilo ase Mzantsi Afrika ukuqondisa ukufikelela kumajelo ezempilo kuquka ukukhusela inkqubela yenkathalelo futhi ngokukodwa indima yonoompilo basekuhlaleni kulenkqubo, ukwazisa umgomo

Yintoni endingayibuzwa xa ndinokuthatha ixaxheba?

Uzakucelwa ukuba uthathe inxaxheba kwingxoxo ethe vetshe nakwiqela lengxoxo elibizwa ngokuba ……..Ukuba unguNontlalontle wasekuhlaleni (CHW)sizakujonga umsebenzi wakho ngemini ophangela ngayo kwi phase yesithathu yoluphando.

Oluphando luzakwenziwa apha ekuhlaleni kuleNgingqi ekuthiwa Lubisi nase Stofland apha e De Doorns, kwiNtshona Koloni. Udliwano ndlebe ngalunye luzakuthatha kangangeyure ukuya kwezimbini. Oluphando luzakuqhuba kangangeenyanga ezintathu.

Le ntlobo yemibuzo izakubuzwa kubafiki nako nontlalo-ntle basekuhlaleni izakubuza ngezimvo zabo nangemisebenzi yezempilo, necala elizisa inkonzo zempilo nentlonipho. Abasebenzi bezempilo bengingqi, abaphathi, nabasebenzi bezempilo bazakubuzwa imibuzo edibene ngokubanzi nendima ezisa ulwazi kungenelelo nabafiki (migrants)

Ingaba ukubandakanyeka kwam koluphando kuzogcinwa kuyimfihlo?

Abaphandi bathembisa ukukhusela ubuwena kunye nendlela onikelel ngayo. Ukuqinisekisa imfihlelo yakho, uzonikwa inombolo eyehlukileyo ukuze igama lakho kunye nobuwena bugcinwe buyimfihlelo. Kuzakubakho isikhombisi (identification key), umphandi azakusisebenzisa ukunxulumanisa udliwanondlebe nobuwena, futhi ngumphandi yedwa azakubanokufikelela kwesisikhombisi (identification key).

Ukuqinisekisa imfihlelo yakho, kuyakuthi kusetyenziswe ikhowudi yezikhombisi yodwa kuzo zonke iincwadi zenkcukacha ezizakuthi zisetyenziswe, ulwazi luzakugcinwa lukhuselekile kwindawo evalelekileyo yogcino futhi naluphi na ulwazi olukwiincwadana zekompiyutha zizaku khuselwa ligama elinomkhethe(iphasiwedi). Ukuba sibhala isibhengezo ngoluphando, ubuwena buzakukhuseleka.

Olu phando luzakusebenzisa amaqela engxoxo ngoko ke ingqinisekiso yokugcina ubuwena buyimfihlelo ixhomekeke kubathathi nxaxheba beliqela lengxoxo ukugcina imfihlelo.

Zithini iingozi zoluphando?

Zingaba khona iingozi ngoku thatha inxaxheba koluphando.

Lonke unxulumano lwabantu kunye nokuthetha ngeziqu okanye abanye abantu lunobungozi obukhoyo. Kodwa ke sizakuzinciphisa iingozi futhi sizakuthatha amanyathelo ukukuncedisa

ukuba uye wangaphatheki kakuhle, ngokwasengqondweni okanye ngexesha lokuthatha kwakho inxaxheba koluphando. Apho kukho imfuneko khona, indlela efaneleyo yokudlulisela kucwephesha izakukwenziwa ukufumana uncedo okanye ungenelelo olungakumbi.

Udliwanondlebe olunzulu luzakuthabatha ixesha elininzi futhi lungenza udinwe kungoko ke sizakunikezela ngokutya okuncinci kubathathi nxaxheba

Ziintoni iinzuzo koluphando?

Olu phando alwenzelwanga ukukunceda wena buqu, kodwa iziphumo zinganceda umphandi afunde kabanzi malunga nokufikelela kwinkathalelo yezempilo kubafiki futhi nenkqubela yenkathalelo yabo bafiki. Siyathemba ukuba, kwixesha elizayo abanye abantu bangazuza kolu phando ngenxa yokuqonda okungcono yendlela zokuqondisa ngokusebenzisa amajelo enkathalo kweezempilo ukuze kufunyanwe inkathalelo yezempilo engcono futhi inkqubela yenkathalelo engcono.

Kunyanzelekile ndibekoluphando kwaye ndingarhora nangaliphi na ixesha?

Inxaxheba yakho koluphando ayinyanzeliswa konke konke. Ungakhetha ukungathabathi inxaxheba konke. Ukuba ngaba uthathe isigqibo sokuthatha inxaxheba koluphando, ungarhoxa nangalipi na ixesha. Ukuba wenze isigqibo sokuba ungathathi inxaxheba koluphando okanye ukuba uyarhoxa nangaliphi na ixesha, awuzukohlwaywa okanye uphulukane namalungelo akufaneleyo.

Ndenza njani xa ndinemibuzo?

Olu phando lwenziwa ngu **Nafeesa Jalal, Department of Public Health** kwidyunivesithi yeNtshona Koloni. Ukuba unemibuzo malunga noluphando, nceda nxulumana no Nafeesa Jala kuledilesi ilandelayo:

Oluphando luququzelelwa ngu **Nafeesa Jalal, Department of Public Health** at the **University of the Western Cape**. Ukuba unemibuzo malunga noluphando nceda nxulumana no Nafeesa Jalal kuledilesi ilandelayo:

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Ukuba uthe wanemibuzo malunga noluphando ngamalungelo akho nje ngomphathi nxaxheba okanye ufunea ukusixelela malunga neengxaki ezimayela noluphando nceda nxulumane:

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Imvume yokuqhutywa koluphandoifumaneka kwiUniversity of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: *to be inserted on receipt thereof from SR*)

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Ditsebiso tsa lekane - (Sotho translation)

Thaetelele ya Porojeke: Temo ka basebetsi ba molakolako laetsana tshepetso ya bophelo bo bo bottle: Kenello, tswela pele ya thlokomelo le karolo ya tswela pele ka basebetsi ba setjhaba sa bophelo bo bottle ko De Doorn, Kapa Boipehiremela.

Dithutho ke tsa mabopi le eng?

Ke dipatlisiso tsa porojeke e itshwereng ke morutwang wa PHD Nafeesa Jalal ko university ya Kapa Boipehiremela. Re mema wena ho momahatsa mono dipatlisiso tsa porojeke hobane re batla ho ithuta ka basebedi bat emo ba malakolako ho thola le ho kena thlokomelo ya bophelo yo bottle. Re batla ho ithutha mabapi le boiphihlelo le maikutlo a batho jwalo ka: basebetsi ba baholo (dilemo tsa leshome le metso e robedi ka tsofalo hoba hodimo), ntja hoba nako e telele molakolako kappa tswa Afrika Borwa le dingwe mafatshe; bane ban a le bothata le dipuo le bane ba se ke, batho bana le tlaleho tshebedisang di patlisiso le bane bas eke ba sebedisa kakanyo; setjhaba sa thlokomelo ya bophelo yo bottle ba sebetsang ho Lubisi kapa Scofland, le basebetsi ba athlokomelo ya bophelo ya bottle ya temo ya basebetsi ba malakolako le CHWs. Maikemisetso a kakanyo ya porojeke ee ke ho utlwasisa temo o ya molakolako ho tlou ya naha ya beine setereke sa Kapa Boiphiremela porofensi ho Afrika Borwa o kganna tsepetso ya thlokomelo ya bophelo ya bottle ya Afrika Borwa. Ka tlhompho ho kena kakanyong ya thlokomelo ya bophelo yo bottle hob ala le tshireletsoe tswela pele ka thlokomelo, le e neipileng ka karolo ho setjhaba sa basebetsi ba bophelo bo bottle mono ho ketsahalo, ka taelo ho tseba tsamaiso le ketso.

Ketla otswa eng ha ke dumela ho mamahatsa?

Wena kathato o tlo botswa ho mamahatso ka botebo dipuisano le sehlopha bitswa hloko sehlopha dipuisano. Ha o le setjhaba sa basebetsi ba vophelo bo bottle, ka thato re tla batlisisa imosebetsi wa hao ka tsatsi la karalo tharo tsa dithuto tse ena.

Badulo ba dithuto tse ena ka thato ditla bah o setjhabeng sa Lubisi le Stofland ko De Dooms, ko Kapa Boiphirimela. Tlhahlobo ya mong le mong ka hohle e tla ba nngwe hoba pedi ka nako. Nako k abo abarola ya dithuto ka hohle e tla ba dikgwedi tse tharo ka kakaretso.

Mofuta wa dipotso tse ditlo tse ditlo botswang ho malakolako le basebetsi ba thlomokelo ya bophelo yo bottle bot la potoloha ka hohle le boiphitlelo ba bona le dipatlisiso tsa thlokomelo ya bophelo yo bottle, le karolo tse batla di bapala ka ho fana dipatlisisi ho thlookomelo ya bophelo ya bottle; ka hlompho. Dikaralwana tsa bophelo bo bottle tsa basebetsi, balaodi le thoto batsamaisa ba thlokomelo ya bophelo yo bottle e tla botswa dipotso potolohang ka bohle le dikaralo tsa bona ka he e le basebeletsi le dipatlisiso tsa bona ka hare ha kanelelaho tsa bona le malakolako.

Mamahatso tsa ka ho dithuto tse ena di tla bolokwa sephiri?

Dipatlisiso di gala ho tshireletso boitsebiso ba hao le hlaho ya dikabelo tsa hao. Ho tiisetsa bokunutu ba hao, ka thato o tla aba ID e fapaneng hore lebitso le boitsebiso ba hao ka thato di tla aba sephiring. O itela u tsireledzea, rido shumisa dzicoudu kha dzi bammbiri dza vheinwi dzine ra do di shumisa, zwishumisa zwido valeliwa zwa khineliwa fhethu ho tsireledzeaho.

Ndi dzifhio khakhathi dza iyi thoduluso?

Hu ngavha na thaidzo thukhu kha u dzhenelela thodisiso iyi.

Zwothe u amba nga ha iwe na nga ha vhathu vhanwe zwo hwala vhudifhunduleli khaho. Ri do fhungudza idzo khakhathi ngau ita zwothe zwine ra nga kona thusa uri muthu avhe o vhofholowaho musi ni tshi amba, kana u fhindula musi ni khou amba na rine kha thodulisuso

heyi. Arali hungavha na thodea ri do zwi isa na kha vha divhi uri vha kone u thusa nga hune vha nga kona ngaho.

Nga vhudalo thodisiso dzone dzia dzhia tshifhinga tsha muthu lunu muthu a fhedza o farwa nga tshineto na nga u bvafha, fhedziha ri do nekedza zwiliwa nga hune ra nga kona ngaho.

Ndi afhio malamba a thodisiso idzi?

Thodisisi iyi ayo ngo itelwa u thusa inwi fhedzi,fhedzi ha inga thusa uri mutodisis a gude uri u netshedzwa ha vhabvannda thuso ya mutakalo nau isa phanda na uvha nekedza yone. Ri thembea uri na minwahani Idaho vhanwe vhathu vha nga guda nga pfunzo ine ya dovha yo wanala nau alusa u thogomela vhabva nnda.

Ndia thoda uvha kha thoduluso iyi naa kana ndia kona ubva khayo tshifhinga tshinwe na tshinwe naa?

U dzhenelela thodiluso iyi azwi kombetshedzwi naluthihi. Ni nga nanga usa vha tshipida. Arali na nga nanga uvha tshipida tsha thoduluso iyi, ni nga di litsha tshifhinga tshinwe na tshinwe. Ahuna uri ni nga latiswa, kana na sa wane ndugelo dzanu dzine no dzi swikelela kha thodisiso iyi.

Arali ndina Mbudziso?

Thodiluso iyi I khou itwa nga Nafeesa Jalal, depathimende ya Nguda Mutakalo kha yunivesithi ya Kapa Boipehiremela. Arali ni na mbudziso ya ngudo iyi, ni ngwa kama Nafeesa jala kha:

55305-60 Absolute Avenue, Mississauga, ON L4Z 0A9, Canada; Lutingo: 1-416-857-5273; Emaili: nafeesajalai1@gmail.com

Arali nina mbudziso malugana na thodisiso iyi, nanga ha ndugelo yanu kana u toda u pota mulandu na thaidzo dzena tangana nadzo kha ngudo iyim kjha vha kamane na:

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Tshikolo tsha Nguda Mutakalo
Thoho ya tshikolo
Yunivesithi ya Western Cape
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Prof José Frantz
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CONSENT FORM - (ENGLISH)

Title of Research Project: Understanding Access and Navigation to Health Services, Continuity of Care and the Role of Community Health Workers: How do the Agricultural Rural Migrant Communities of Lubisi and Stofland in De Doorns, Western Cape, manage their health?

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

PARTICIPANT'S NAME…….

PARTICIPANT'S SIGNATURE……

DATE……

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Vrywaarens vorm - (Afrikaans)

Titel van navorsing projek: Landbou migrerende navigeer die gesondheid stelsel: toegang, kontinuiteit van sorg en die rol van die gemeenskap gesondheidwerkers in De Doorns, Wes-Kaap.

Die studie was aan my verduidelik in ‘n taal wat ek verstaan. Enige vrae wat ek gehad het was geantwoord. Ek verstaan wat van my verwag is en ek verstaan dat ek deel neem uit my eie verkiesing en wil. Ek verstaan dat my identiteit nie beskikbaar vir enige iemand sal wees nie. Ek verstaan ook dat ek kan enige tyd van die studie uitrek sonder om ‘n rede te gee en sonder om bang te wees vir enige negatiewe gevolge of van die velore van enige voordele.

NAAM:……

HANDTEKEN……

DATUM……

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IPHEPHA MVUME - (Xhosa/Zulu translation)

ISIHLOKO SALEPROJECTHI: Abasebenzi bezolimo abangabafiki bazama ukumelana nenkqubo yezempilo ukufukeleleka ukuqhuba kononophelo kunye nendima yooNompilo e De Doorns eNtshona Koloni

Olu phando lucacisiwe kum ngolwimi endiluqondayo. Imibuzo yam ngoluphando iphenduliwe. Ndiyayiqonda ukuba inxaxheba yam izakubandakanya ntoni futhi ndiyavuma ukuthatha inxaxheba ngokuzikhethela nangokuthanda kwam. Ndiyayiqonda ukuba iinkcukacha ngam azizokubhentsiswa nakubanina. Ndiyayiqonda ukuba ndingarhoxa koluphando ngaphandle kokunika isizathu futhi nangaphandle nangaphandle koloyiko lwemiphumela emibi okanye ukuphulukana nenzuzo.

Igama lomthathi nxaxheba……..

Utyikityo lomthathi nxaxheba…….

Umhla……

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FOCUS GROUP CONSENT (CONFIDENTIALITY BINDING) FORM

Title of Research Project: Understanding Access and Navigation to Health Services, Continuity of Care and the Role of Community Health Workers: How do the Agricultural Rural Migrant Communities of Lubisi and Stofland in De Doorns, Western Cape, manage their health?

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name……..

Participant's signature……..

Date……

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FOKUS GROEP VERETROULIK BINDEND VORM

Titel van navorsing projek: Landbou migrerende navigeer die gesondheid stelsel: toegang, kontinuiteit van sorg en die rol van die gemeenskap gesondheidwerkers in De Doorns, Wes-Kaap.

Die studie was aan my verduidelik in ‘n taal wat ek verstaan. Enige vrae wat ek gehad het was geantwoord. Ek verstaan wat van my verwag is en ek verstaan dat ek deel neem uit my eie verkiesing en wil. Ek verstaan dat die navorsers my identiteit vir niemand sal beskikbaar maak nie. Ek verstaan ook dat ek kan enige tyd van die studie uitrek sonder om ‘n rede te gee en sonder om bang to wees van enige negatiewe gevolge of van die velore van enige voordele. Ek vertstaan dat dit van die deelnemers sal afhang om die gespreke met vertroulikheid te behandel binne en buite die fokusgroepe.

Hiermee onderneem ek om die vertroulikheid van die besprekings te handaf in die fokusgroepe deur nie die bekendmaking van die identiteit van die ander deelnemers of enige aspek van hul bydraes tot persone buite die fokusgroep deel nie.

NAAM:…….

HANDTEKEN……

Datum……

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E-mail: *soph-comm@uwc.ac.za*

IPHEPHA MVUME

ISIHLOKO SALEPROJECTHI: Abasebenzi bezolimo abangabafiki bazama ukumelana nenkqubo yezempilo ukufukeleleka ukuqhuba kononophelo kunye nendima yooNompilo e De Doorns eNtshona Koloni

Olu phando lucacisiwe kum ngolwimi endiluqondayo. Imibuzo yam ngoluphando iphenduliwe. Ndiyayiqonda ukuba inxaxheba yam izakubandakanya ntoni futhi ndiyavuma ukuthatha inxaxheba ngokuzikhethela nangokuthanda kwam. Ndiyayiqonda ukuba iinkcukacha ngam azizokubhentsiswa nakubanina ngabaphandi. Ndiyayiqonda ukuba ndingarhoxa koluphando ngaphandle kokunika isizathu futhi nangaphandle nangaphandle koloyiko lwemiphumela emibi okanye ukuphulukana nenzuzo. Ndiyaqonda ukuba imfihlelo ixhomekeke kubathathi nxaxheba beliqela lengxoxo ukugcina imfihlelo.

Ndiyavuma ukugcina imfihlelo yezongxoxo zalamaqeIa engxoxo ngokungabhentsisi nkcukacha ngabanye abathathi nxaxheba okanye naluphina igalelo kubantu abangaphandle kweliqela.

Igama lomthathi nxaxheba……..

Utyikityo lomthathi nxaxheba……..

Umhla……

APPENDIX 2: INTERVIEW GUIDES, NON-PARTICIPANT OBSERVATION GUIDE AND CARE TRAJECTORY INTERVIEW GUIDE

INTERVIEW GUIDES

UNIVERSITY OF THE WESTERN CAPE

PRIVATE BAG X 17, BELLVILLE 7535, SOUTH AFRICA

Tel: +27 21-959-2809, Fax: 27 21-959-2872, Cell: will update with current #

E-mail: nafeesajalal1@gmail.com, czarowsky@gmail.com

INTERVIEW GUIDE - Agricultural Migrants

Project Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

Introduction:

Thank you for participating in this research. As I previously discussed, our aim is to understand the different healthcare experiences that African migrants, like yourself, and your host communities have encountered. We would like to know what your experiences have been surrounding access to healthcare and continuity of care. Also, we would like to know if community healthcare workers (CHWs) or other facilitators have been able to assist you in accessing care, and how. We want to know if you can identify any barriers that made it difficult to obtain the healthcare you needed as this would allow us to understand the challenges that exist. This will focus on questions that will assist us to understand and illustrate your story. We want to know why you chose to live in this community (Lubisi or Stofland), how you take care of your health here and as you travel between communities, , how important healthcare is (compared to other priorities) and whether you have had any positive or negative experiences when accessing care. This interview will take approximately an hour and if we have your permission, we would like to contact you for follow up questions or conversations. We will also check back with you to make sure that we have accurately captured your experiences.

I would like you to feel free to ask questions, make comments or address points that are important to you but that I have missed. Please note, should you feel uncomfortable, you have the absolute right to stop the interview at any time, without consequence.

Demographics and Background:

1. May I please ask you your name, and any other name you use, so that I may use during this interview? And in order to protect your privacy, do you have a name you would like me to use in my reports? We will not be using real names in our reports.

2. What is your age?

3. Where did you originally come from?

4. Please tell me all the locations you have lived in the last year.

5. Where did you last live?

6. Where do you currently live?

7. Approximately how long to you plan to stay here?

8. Where will you go next?

   (Probe: Let me check that I have this right: (review timeline and trajectory))

   (Probe: Is this a typical year? (probe for variation among patterns))

9. Can you describe your life here right now? Are you currently employed on the farms? How many farms are you working on? How did you come to know about this job opportunity. (Probe to get a sense of work and life patterns)

10. Before moving here (Lubisi/Stofland) what were you doing?

Migration History:

11. Please tell me how often you travel and what is the main reason for travelling? Do you move back and forth? If so, then how often do you move back and forth and what is your reason for doing so?

    (Probe: Who are the people who have helped them in navigating transportation, who provided them with information, how did they decide to be the one to travel?)

    (Probe: Are they moving due to agricultural work or accessing healthcare or for other specific reasons?)

12. What are some of the challenges that you have faced while travelling? How did you mitigate those challenges?

13. What are some things which have made your migration here (Lubisi/Stofland) easier?

(Probe: Do you have support systems (family, friends, colleagues etc.)

Accessing Healthcare Services:

14. We know that people have many concerns and priorities in their lives, and I am trying to understand where health fits into this for different people. How important is health to you?

(Probe: what do you do to stay healthy?)

15. (Probe: Please explain: What do you do to take care of your health? What do you think puts your health at risk?)

16. When you are away from your home of origin, and you get ill, who takes care of you?

17. If you need healthcare do you know where to go? How did you know where to go? Can you give me an example?

18. (Probe: Who gave them the information regarding the medical facilities? Probe for specific examples and details)

19. How do you know you have to seek care?

(Probe: Do you usually go only when you are feeling ill, or do you routinely for a check up (for yourself, your dependents, etc) or for other reasons?)

20. If you do not access services, why?

(Probe: What are the perceived barriers to them when accessing services?)

Continuity of Care:

21. When you move from one farm to another, is it important for you to find out where you healthcare facility is located? If so, who do you ask and how do you know who to ask?

(Probe: Understand how they navigate services.)

22. Do you have any health conditions for which you need ongoing care , such as taking medicines or getting repeated tests? (For example, conditions like diabetes, TB, high blood pressure, HIV, and others).

23. How do you manage your condition when you move?

    (Probe: self care? referral? obtain medication?)

    (Probe: Can we go through the history and the ongoing story of this condition? (how/when diagnosed, how it was managed, the history over time including now and in future; any interruptions of care and if so why (and if not - how have you managed to stay on top of things, avoid gaps etc)

    (Probe for facilitators and barriers to care and continuity, probe for what prompts attention/action, probe for roles of family members, health workers, CHWs, employers, others

24. How important is it for you to seek care when you move from one farm to another?

25. If you think it is important, why do you think it is important for you to seek care? If not a priority, why and what is a priority instead?
    (Probe: family dependency, self importance?)

26. Would it be helpful if the healthcare workers (nurses, facility managers, CHWs etc.) in your area linked you with other healthcare workers in areas where you travel? If so, how would this be helpful to you?

    (Probe: referral process, added services which CHWs can offer, did you feel CHW involvement will get you the care you need in a timely fashion?)

27. I would like to go back now and check if I have understood, or if I have missed anything important (recap; probe; invite additions and clarifications and corrections)

Role of CHWs:

In this last part of our conversation, I want to understand the roles of community health workers and how people in the community interact with them and see their roles.

28. Can you tell me something about community health workers and what you have experienced with them or heard about their roles here?

    (Probe: Do you know any specific CHWs? In what context have you encountered or heard about them and their work?)

    (Probe: What else do CHWs do in the community?)

29. Have you ever sought assistance from the CHWs when accessing healthcare? If so, how was your experience, was it helpful, and would you go back? If not, why, and what would you change to make your experience better?

    (Probe: If you yourself have not interacted with CHWs but know someone who has, can you tell me about that situation or experience?)

30. What role do you think CHWs should play in the community?

31. What role do you think CHWs should play in helping you to get the care that you and others need?

    Thank you for your time and sharing your story with me. Is there anything further you would like to add to our discussion today that I may have missed or you would like to share? If you would like to contact us, please feel free to contact me (or Christina at 079 336 1066). Also, may I contact you again if I have any further questions?

UNIVERSITY OF THE WESTERN CAPE

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E-mail: nafeesajalal1@gmail.com, czarowsky@gmail.com

INTERVIEW GUIDE – CHWs/health workers

Project Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

Introduction:

Thank you for participating in this research. As I previously discussed, our aim is to understand the different healthcare experiences that African migrants have encountered. We would like to know how your experiences have been with respect to helping to facilitate access to healthcare and continuity of care for these migrants. Also, we would like to know if community healthcare workers (CHWs), such as yourself or other facilitators have been able to assist the migrant population in accessing healthcare and providing continuity of care successfully. We want to know if you can identify any barriers that exist for yourself when providing access to care and ongoing care for the migrants in your community. We would like to understand if there are any barriers you recognize that may exist for the migrants who would like to access healthcare services and ongoing care. This would allow us to understand the challenges that exist. Our aim is to understand your role in the health sector within the community. This interview will focus on questions that will assist us to understand and illustrate your story. We want to know why you chose to work in the communities of Lubisi and/or Stofland, what role you play in offering healthcare and whether you have had any positive or negative experiences when offering access to care and ongoing care. The duration of this interview will be approximately an hour and if we have your permission, we would like to contact you for follow up questions. We will also verify your account(s) to assure that we have accurately captured your experiences.

I would like you to feel free to ask questions, make comments or address points that are important to you but that I have missed. Please note, should you feel uncomfortable, you have the absolute right to terminate the interview without consequence.

Demographics and Background:

1. May I ask you your name, and any other name you use or would like me to use, so that I may use during this interview and in my reports? (N.B. Real names will not be used in the reports)

2. What is your age?

3. Are you from Lubisi or Stofland? Where did you originally come from?

4. Do you live in the community in which you are employed as a CHW?

5. Can you describe your life here? How did you decide to become a CHW?

6. Please Tell me about your training and the supervision and support you have received.

   (Probe: what has worked well and not so well/what could be improved? With training? Supervision and support?)

7. Before becoming a CHW what did you do?

Role and Experiences as a CHW:

8. How long have you been a CHW? Have you worked as a CHW in other communities?

9. What does a typical day/week look like for you at work? Please explain all your duties from the beginning until the end of the day.

10. Do you have interactions with the agricultural migrant populations? If so, what have your experiences been?

11. Have you helped them in navigating access to services? If so, in what capacity?

   (Probe: how have you helped them in navigating transportation, providing them with information, and what kind of information have you provided?)

12. What are some aspects of your job which have made it easier for the migrants to receive services?

13. Do you have support systems which assist you in your role as a CHW?

   (Probe: facilitators, colleagues, health sector etc...)

14.What are some challenges you face when you work with the migrant populations? How do you mitigate those challenges? Can you please provide an account or a specific example?

15. What are some factors that you feel are rewarding for you as a CHW?

16. Do you think the migrant populations know what role you play in the community?

17. Do migrants commonly seek your assistance when attempting to access healthcare? If so, what do you think their experience is like? What would you change to make their experience better?

18. Would it be helpful if the CHWs in your area linked migrants with CHWs in areas where they travel? If so, how would it be helpful to them and you?

(Probe: referral process, added services which CHWs can offer, did you feel CHW involvement will get them the care they need in a timely fashion?)

19. How do you think you can further improve access to healthcare and encourage continuity of care?

Accessing Healthcare Services:

20. How important do you think health is to the migrant populations? Why?

(probe: Please explain. What do you think puts their/community's health at risk?)

21. Do you think that migrants know how to access services? If so, how? If not, then why not? What is your role in assisting in this access to healthcare services?

(Probe: Who would give them the information regarding the medical facilities?)

22. What are the typical reasons that migrants seek healthcare services? If they do not, why not?

(Probe: What are the perceived barriers to the migrants when accessing services?)

Continuity of Care:

23. As migrants move from one farm to another, do you feel there is a need to transfer their care to the next community they work in? If so, why? If not, why not?

24. When migrants come into the community do you note a pattern of health seeking behaviours? Whose responsibility do you think it is to guide migrants to seek healthcare? Please explain.

(Probe: Understand navigation of services.)

25. Typically, which medical conditions do you encounter most in the migrant populations? Do you feel these migrants are compliant with medical treatment? If not, why not? If so, why do you think they are not compliant?

26. How do you think they manage their conditions when they move?

(Probe: self care? referral? obtain medication?)

27. How important is it for them to seek care when they move from one farm to another?

Thank you for your time and sharing your story with me. Is there anything further you would like to add to our discussion today that I may have missed or you would like to share? If you would like to contact us, please feel free to contact me.....(or Christina at 079 336 1066). Also, may I contact you again if I have any further questions?

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INTERVIEW GUIDE – Managers/policy makers

Project Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

Introduction:

Thank you for participating in this research. As I previously discussed, our aim is to understand the different healthcare experiences that African migrants have encountered. We would like to know how your experiences have been with respect to initiating, creating, and implementing policies and programs surrounding access to healthcare and continuity of care for these migrants and more generally for people who move because of work or other reasons. Also, we would like to understand the formal and informal roles of community healthcare workers (CHWs) or other facilitators in assisting the migrant population in accessing healthcare and providing continuity of care. We want to know if you can identify any barriers that exist for yourself, as a policy maker, when initiating, creating or implementing these policies pertaining to access to care and ongoing care for the migrants in the communities you serve. Also, we would like to understand if there are any barriers you recognize that may exist for the migrants who would like to access healthcare services and ongoing care. This would allow us to understand the challenges that exist. Our aim is to understand your role in the health sector as a policy maker or implementer of policies within the community. This interview will focus on questions that will assist us to understand and illustrate your story. We want to know why you chose to work in the health care sector in the communities of Lubisi and/or Stofland, what role you play in offering healthcare and whether you have had any positive or negative experiences when creating policies surrounding access to care and ongoing care. The duration of this interview will be approximately an hour and if we have your permission, we would like to contact you for follow up questions. We will also verify your account(s) to assure that we have accurately captured your experiences.

I would like you to feel free to ask questions, make comments or address points that are important to you but that I have missed. Please note, should you feel uncomfortable, you have the absolute right to terminate the interview without consequence.

Demographics and Background:

1. May I please ask you your name, and any other name you use, so that I may use during this interview and in my reports?

2. What is your age?

3. Are you from Lubisi or Stofland? Where did you originally come from?

4. How did you decide to become a policymaker?

(Probe: educational and social backgrounds)

5. Before becoming a policy maker what did you do?

Role and Experiences as a Policy maker/Manager:

6. How long have you been in this role? Have you worked in other regions of the country?

(Probe: Have your experiences in other regions influenced the healthcare policies in the Western Cape?)

7. What does a typical day/week look like for you at work? Please explain all your duties from the beginning until the end of the day.

8. Do you have interactions with the agricultural migrant populations? If so, what have your experiences been? Have these interactions influenced your policy creation?

9. How have your policies and programs helped migrants navigate access to services? If so, in what capacity?

10. What are some aspects of your job which have made it easier for the migrants to receive services?

11. Do you have support systems which assist you in your role?

(Probe: facilitators, colleagues, health sector etc...)

12. What are some challenges you face when you create policies relating to the migrant populations? How do you mitigate those challenges?

13. What are some factors that you feel are rewarding for you as a policy maker?

14. How do you evaluate your policies and programs to ensure that they are benefitting to the communities at large?

15. Do you think your current policies and programs sufficiently addressing migrant health concerns? If not, what would you suggest as changes to enhance healthcare services for this growing population?

16. Do you think continuity of care is a challenge currently for the migrant population? If so, how do you ensure that continuity of care addressed in the healthcare policies being implemented?

17. Would it be helpful if the healthcare facilitators in your jurisdiction linked migrants with other healthcare facilitators in areas where they travel to ensure continuity of care? If so, how would it be helpful to them and you?

(Probe: referral process, added services which frontline healthcare workers can offer, and do you feel healthcare involvement will get them the care they need in a timely fashion?

18. How do you think you can further improve their access to healthcare and encourage continuity of care through policy making or implementing programs?

Accessing Healthcare Services:

19. How important do you think health is to the migrant populations? Why?

(Probe: Please explain. What do you think puts their/community's health at risk?)

20. Do you think that migrants know how to access services? If so, how? If not, then why not? What is your role in assisting in this access to healthcare services?

(Probe: Who would give them the information regarding the medical facilities?)

21. What are the typical reasons that migrants seek healthcare services? If they do not, why not?

(Probe: What are the perceived barriers to the migrants when accessing services?

Continuity of Care:

22**.** As migrants move from one farm to another, do you feel there is a need to transfer their care to the next community they work in? If so, why? If not, why not?

23. When migrants come into the community do you note a pattern of health seeking behaviors? Whose responsibility do you think it is to guide migrants to seek healthcare? Please explain.

(Probe: Understand navigation of services.)

24. Typically, which medical conditions do you believe need to be addressed the most in the migrant populations? Do you feel these migrants are compliant with medical treatment? If not, why not? If so, why do you think they are not compliant?

25.How does non-compliance impact the health of the general population?

26. How do you think the agricultural migrants manage their medical conditions when they move?

(Probe: self care? referral? obtain medication?)

27. How important is it for them to seek care when they move from one farm to another?

Thank you for your time and sharing your story with me. Is there anything further you would like to add to our discussion today that I may have missed or you would like to share? If you would like to contact us, please feel free to contact me.....(or Christina at 079 336 1066). Also, may I contact you again if I have any further questions?

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INTERVIEW GUIDE - FOCUS DISCUSSION GROUP (FDG)

Project Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

Introduction:

Thank you for participating in this research. As previously discussed, our aim is understanding the different healthcare experiences that African migrants in the communities have encountered. We would like to know what the experiences have been surrounding access to healthcare and continuity of care, and to understand the role of community healthcare workers (CHWs)/facilitators in doing their work and assisting migrants in accessing care.

This Focus Group Discussion (FGD) will assist us to understand and clarify what we have heard and what we think we have learned – we want you to help us understand what people have told us, and make sure we are on the right track in how we are interpreting things. The discussion will be approximately two-hours and if we have your permission, we would like to contact you for follow up questions.

I would like you to feel free to ask questions, make comments or address points that are important to you but that I have missed. But the main point is for you to discuss amongst yourselves! Please note, should you feel uncomfortable, you have the absolute right to withdraw from the FGD without consequence.

(questions to be drafted based on findings of earlier phases, likely in the following domains:)

1. Discussion of the migrant accounts regarding access to healthcare as compared to the accounts provided by CHWs and policy makers/managers.

2. Discussion of the migrants experiences to continuity of care and the challenges they have faced versus the accounts of the CHWs and policy makers.

3. Discussion of the role that CHWs play in providing access to healthcare and continuity of care.

4. Discussion on conflicting accounts that arise between the different groups.

Thank you for your time and for sharing your thoughts amongst each other, and with me. Is there anything further you would like to add to our discussion today that I may have missed or you would like to share? If you would like to contact us, please feel free to contact me.....(or Christina at 079 336 1066). Also, may I contact you again if I have any further questions?

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E-mail: nafeesajalal1@gmail.com, czarowsky@gmail.com

Project Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

Introduction:

Thank you for participating in this research. As I previously discussed, our aim is understanding the different healthcare experiences that African migrants have encountered – and understanding the roles and experiences of community health workers (CHWs) in this community.

We will be documenting your activities, timelines, and any conversations/comments/reflections. This will be a two-day accompaniment or "job shadowing" which will focus on your work day and will involve pure observation and noting what you do. I will not be intervening in your work in any way, except to ask permission to observe interactions over the days by saying I am accompanying you as you do your work to learn about your work in the community. If anyone is uncomfortable or does not want me to be present during your interactions, I will stay outside and ask you to describe the interaction or activity afterwards.

At the end of day 2 or on the following day we would like to have an unstructured discussion with you to allow us the opportunity to reflect on the past two days. We will focus on identifying what you think was important, typical or unusual. Also, we would like to highlight any concerns or issues encountered in the day to day processes that may be the cause of any constraints. We would like to ask you how you felt about the last two days of the shadowing.

I would like you to feel free to ask questions, make comments or address points that are important to you but that I have missed. Please note, should you feel uncomfortable, you have the absolute right to terminate the interview or ask me to stop the observation without consequence.

Thank you for your time and allowing us to shadow you at work. If you would like to contact us, please feel free to contact me....(or Christina at 079 336 1066). Also, may I contact you again if I have any further questions?

Guidelines for observation:

- Introduce yourself and ask permission to observe all activities; otherwise minimize interactions

between yourself and the CHW and between yourself and clients or other people

- Accompany throughout the day and note or voice-note all activities
- Note times of starting, stopping, and transitioning/transport
- Note every person contacted (face to face, by phone etc)
- Note and be able to describe activities and interactions
- Note "mood" or tone of interactions
- Do not encourage interaction with you - but respond to any comments or questions posed to you, without offering any judgment (positive or negative) or advice

Guidelines for debriefing:

Try to minimize questioning and rather have a conversation, mostly listening. Start with an open question like "So, tell me about these past two days" and listen to how the CHW describes it, what THEY flag etc.

Probe:

- What do you think was important, typical or unusual?

- Any concerns or issues encountered in the day to day processes? How have you felt about the last two days of the shadowing?

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INTERVIEW GUIDE - Agricultural Migrants - Care Trajectory

Project Title: Agricultural migrant workers navigating the health system: Access, Continuity of Care and the Role of Community Health Workers in De Doorns, Western Cape

Introduction:

Thank you for participating in this research. As I previously discussed, our aim is to understand the different healthcare experiences that African migrants, like yourself, and your host communities have encountered. We would like to know what your experiences have been surrounding access to healthcare and continuity of care. Also, we would like to know if community healthcare workers (CHWs) or other facilitators have been able to assist you in accessing care, and how. We want to know if you can identify any barriers that made it difficult to obtain the healthcare you needed as this would allow us to understand the challenges that exist. This will focus on questions that will assist us to understand and illustrate your story. We want to know why you chose to live in this community (Lubisi or Stofland), how you take care of your health here and as you travel between communities, , how important healthcare is (compared to other priorities) and whether you have had any positive or negative experiences when accessing care. This interview will take approximately an hour and if we have your permission, we would like to contact you for follow up questions or conversations. We will also check back with you to make sure that we have accurately captured your experiences.

I would like you to feel free to ask questions, make comments or address points that are important to you but that I have missed. Please note, should you feel uncomfortable, you have the absolute right to stop the interview at any time, without needing to give any reasons and without any consequences for you.

What we are trying to do is to rebuild the detailed histories and social histories of migrants like yourself, to rebuild your story.

We will use a wall calendar to help anchor you visually. I would like you to share your story in as much detail as you can. You may go back and forth and fill in details. We will be taking notes and also recording, with your permission.

1. Let us first start with your overall history of migration and health.

2. Now let us go back and re-visit the various steps of your journey, particularly in relation to what I have been hearing and seeing as I work in this community.

3. I want to understand again how you navigate the health system, who does or did what, who helped (or hindered) and how; what the details are regarding referrals, letters etc.

4. We would like to understand if CHWs, health workers, family and friends and employers have played a role in the story of your health and migration here; is there a balance or what are the dynamics between patient-driven action and provider (or other)-driven action?

5. I want to understand if there were any gaps in care, and if so why and what happened - was it an issue, what happened next etc?

6. Finally, I you want to anchor all that you have said around other life events like their work trajectory. When did you start work here in De Doorns, and how did this impact your continuity of care for your condition?

Thank you for your time and sharing your story with me. Is there anything further you would like to add to our discussion today that I may have missed or you would like to share? If you would like to contact us, please feel free to contact me at **081 091 1627** (or Christina at 079 336 1066). Also, may I contact you again if I have any further questions?

APPENDIX 3: DEPARTMENT OF HEALTH MEMOS

Department of Health
Lefapha la Maphelo
Departement van Gesondheid
Umnyango we zeMpilo
OFFICE OF THE CHIEF DIRECTOR
JHB-WEST RAND REGION
ENQUIRIES: MS C KULA
HEALTH PROGRAMMES
TEL: 011 694 3822
FAX: 011 694 3815

MEMORANDUM

TO : All HOSPITAL CEO's, DISTRICT FAMILY PHYSICIANS AND DISTRICT MANAGERS.

DATE : 04 APRIL 2008

SUBJECT : ACCESS TO THE COMPREHENSIVE HIV AND AIDS CARE INCLUDING ANTIRETROVIRAL TREATMENT.

It has come to my notice that some facilities are denying patients that do not have a South African Identity document access to the comprehensive HIV and Aids care, management and treatment plan including antiretrovirals.This practice is not acceptable.

Kindly note that no patient should be denied access to any health care service, including access to antiretrovirals irrespective of whether they have a South African Identification document or not.

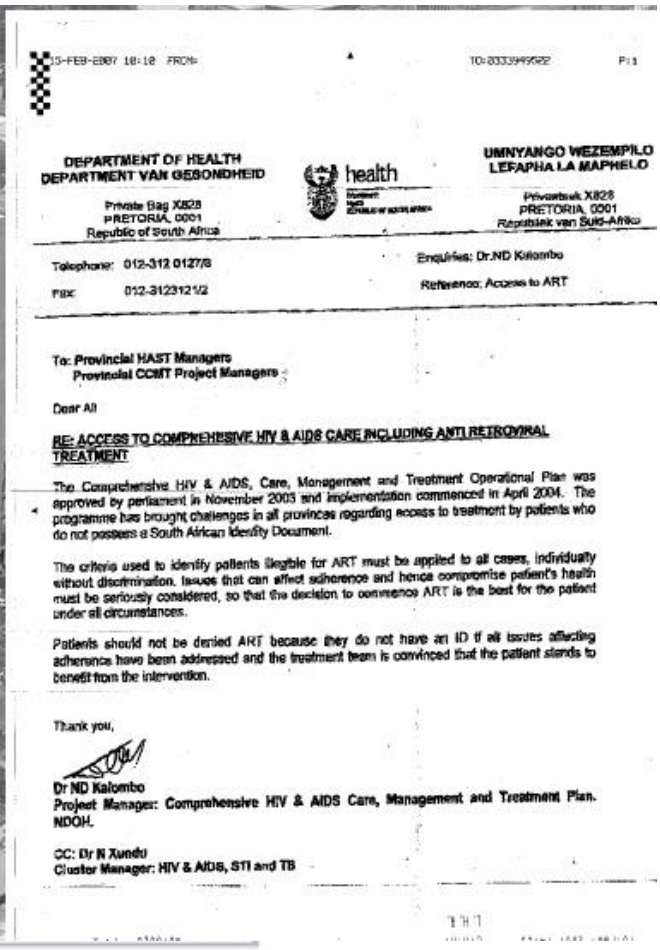
For reference please see attached memorandum.

DR. PMH MADUNA
CHIEF DIRECTOR
REGION A

Office Number 119, 1st Floor, Hillbrow CHC Building,
Corner Klein & Smit Street, Private Bag X21, Johannesburg, 2001
Tel: (011) 6943710 Fax: (011) 694 3815

NDOH memo, 2006

- Clarifies that possession of a South African identity booklet is NOT a prerequisite for eligibility for ART;
- Important for South African citizens as well as non-citizens.



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Enquiries: Dr.ND Kalombo
Reference: Access to ART

To: Provincial HAST Managers
Provincial CCMT Project Managers

Dear All

RE: ACCESS TO COMPREHENSIVE HIV & AIDS CARE INCLUDING ANTI RETROVIRAL TREATMENT

The Comprehensive HIV & AIDS, Care, Management and Treatment Operational Plan was approved by parliament in November 2003 and implementation commenced in April 2004. The programme has brought challenges in all provinces regarding access to treatment by patients who do not possess a South African Identity Document.

The criteria used to identify patients illegible for ART must be applied to all cases, individually without discrimination. Issues that can affect adherence and hence compromise patient's health must be seriously considered, so that the decision to commence ART is the best for the patient under all circumstances.

Patients should not be denied ART because they do not have an ID if all issues affecting adherence have been addressed and the treatment team is convinced that the patient stands to benefit from the intervention.

Thank you,

Dr ND Kalombo
Project Manager: Comprehensive HIV & AIDS Care, Management and Treatment Plan. NDOH.

CC: Dr N Xundu
Cluster Manager: HIV & AIDS, STI and TB

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Thank you.

Dr ND Kalombo
Project Manager: Comprehensive HIV & AIDS Care, Management and Treatment Plan.
NDOH.

CC: Dr N Xundu
Cluster Manager: HIV & AIDS, STI and TB

APPENDIX 4: STUDY PARTICIPANT DEMOGRAPHIC DETAILS

Interview #	Gender	Age	Location of Birth	Current Residence
WS55045	F	50	Zimbabwe	Stofland
WS55085/86/87	M/F	Various (FDG)	Various	Various
WS550046	F	28	Orchard (close to De Doorns)	Stofland
WS550047	F	R.A. forgot to ask	Lesotho	Stofland
WS550048	F	26	Mozambique	Stofland
WS550049	F	R.A. forgot to ask	Mozambique	De Doorns
WS550050	F	30	Lesotho	Lubisi
WS550051	F	42	Lesotho	Lubisi
WS550052	F	R.A. forgot to ask	Lesotho	Lubisi
WS550053/54	F	22	Sterkspruit	Lubisi
WS550055	F	40	Lesotho	Stofland
WS550056	F	33	Lesotho	Stofland
WS550057	F	34	Zimbabwe	Lubisi
WS550058	M	Not audible	Rustenburg	Lubisi
WS550059	F	26	Lesotho	Stofland
WS550060	F	34	Eastern Cape	Lubisi
WS550062	F	29	Stofland	Stofland
WS550061	F	45	Queens Town	Lubisi
WS550063	F	44	Hasiequare (farm in De Doorns)	Stofland
WS550064	F	40	De Doorns	Stofland
WS550066	F	29	Eastern Cape	Stofland
WS550067	F	36		Stofland

			Mphumelelo(near Stofland)	
WS550069	M	33	Free State	Lubisi
WS550070	F	41	Zimbabwe	Stofland
WS550071	F	40	Zimbabwe	Stofland
WS55072/73	F	23	Lesotho	Lubisi
WS550074/75	M	30	Lesotho	Lubisi
WS550076	M	23	Eastern Cape	Lubisi
WS550078	M	37	Zimbabwe	Stofland
WS550079	F	24	Eastern Cape	Stofland
WS550080/81	M	29	Lesotho	Stofland
WS550082/83	F	25	Eastern Cape	Stofland
WS550084	M	22	Eastern Cape	Stofland
WS550088	3F/1M	Various (FDG)	Zim and Lesotho	Stofland/ Lubisi
WS550089	F	31	Lesotho	Lubisi
WS550090	F	39	Zimbabwe	Lubisi
WS550091	F	35	Free State in Qwaqwa	Lubisi
WS550092	F	39	Zwelithemba in Worcester	Stofland
WS550093	F	20	Leighnsberg	Smartytown (DeDoorns)
WS550094/95	M	56	Lesotho	Stofland
WS550096	F	45	De Doorns	RDP housing(De Doorns)
WS550097	F	Various (FDG)	Various	Various

WS550098	F	Various (FDG)	Lesotho	Various/ mostly Lubisi
WS550099	F	34	Lesotho	De Doorns
WS550100	F	Various (FDG)	De Doorns	Various
WS550101	F	25	Lesotho	Lubisi
WS550102	F	23	Lesotho	Lubisi
WS550104	F	29	Lesotho	Lubisi
WS550103	M	48	Lesotho	Lubisi
WS550105	F	31	Lesotho	Lubisi
WS550107	F	37	Zimbabwe	De Doorns
WS50108	F	Not disclosed	De Doorns	Mphumelelo (nearStofland)
WS550109	M	Not disclosed	De Doorns	100km from De Doorns
WS550110	F	41	Zimbabwe	De Doorns
WS550111	F	Not asked	Zimbabwe	De Doorns
WS550112	F	40	Zimbabwe	De Doorns
WS550113	F	43	Zimbabwe	De Doorns
WS550114	F	41	Zimbabwe	De Doorns