EXPERIENCES OF ZIMBABWEANS ON THE PROVISION OF HEALTH CARE AT SELECTED PUBLIC HEALTH CARE CENTERS IN CAPE TOWN, 1994-2009

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of Masters in Sociology in the Faculty of Arts, University of the Western Cape

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KEY WORDS

Migration

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ABSTRACT

EXPERIENCES OF ZIMBABWE ON THE PROVISION OF HEALTH CARE AT SELECTED PUBLIC HEALTH CARE CENTERS IN CAPE TOWN, 1994-2009.

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MA mini thesis, Department of Anthropology/Sociology, University of the Western Cape.

There is a widely held assumption that immigrants have difficulties in accessing public health care services in South Africa. This assumption derives from the experiences of some immigrants in accessing public health care services at some public health care facilities which are all required by law and policy to provide such services. The main aim of the study was to investigate the experiences of Zimbabwean immigrants in accessing public health care services at some public clinics and hospitals in Cape Town. Foucault's theory on power was used to unpack the experiences of Zimbabwean immigrants at these public health care centers.

Zimbabwean immigrant participants were all purposively sampled for the study and medical personnel were randomly sampled. The Zimbabwean immigrants sampled had used public health care facilities in Cape Town. Semi-structured interviews were used to collect data from the Zimbabwean immigrants which were qualitatively analysed using content analysis. Questionnaires were also used to collect data from both the Zimbabwean immigrants and medical personnel and subsequently open-ended questions from the questionnaires were also analysed using content analysis and closed questions were analysed using the Micro-soft excel package of data assessment and statistically presented using pie, bar and line graphs.

Themes that were recurring from the semi-structured interviews and responses from questionnaires suggested that immigrants in their experiences at public health care facilities encountered barriers that included communication problems, negative attitudes and xenophobia from medical staff, policy and practice problems and preferential treatment offered to citizens over non-citizens. Recommendations of what needs to be done to reduce barriers to health care for immigrants were made to all involved in the provision of health care. The study contributed to our understanding of barriers that immigrants encounter in accessing public health care in South Africa as well as the role of citizens in this process.

Date: November 2015

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DECLARATION

I declare that, *Experiences of Zimbabweans on the provision of health care at selected public health care centers in Cape Town, 1994-2009* is my own work, that it has not been submitted for any or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references .

Full name: EDGAR NGONIDZASHE MAFUWA

Signed: ……..

Date: ……..

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Professor Olajide Oloyede, thank you sir for all the support you gave me from the first day we met and the second chance. You are truly inspirational to me. Please continue to do this to other students who may want to go through this academic process.

My wife Levy and daughter Kayla Kunashe Mafuwa you were all there for me through thick and thin. The journey was not easy for the family, but by the grace of God there we are.

My late Sister Mercy Mafuwa (July2015) and late Brother Admore Mafuwa (October 2006), Father Isaac Mafuwa, Mother Theresa Mafuwa and Elvis Mafuwa this is for you guys and all the Mafuwas.

Lastly to the almighty God thank you for your love and blessings.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 BACKGROUND

Africans have always been on the move and there are indications that this mobility is on the rise as migration has become a global phenomenon this twenty first century (Akokpari, 1998). Post-apartheid South Africa has experienced increased influx of forced and voluntary migrants which led South Africa to be the SADC member state with highest rates of cross-border migration (Vearey, 2010). On the other hand migration into South Africa is by no means a new phenomenon. The discovery of diamonds in Kimberly in 1869 and the subsequent discovery of gold in Transvaal in 1886 resulted in the massive movement of migrants from countries in the southern region and beyond into South Africa. Perceptions of South Africa as a country of opportunities were created and the real availability of employment opportunities was found to have played a major role in migrants moving into South Africa (Wentzel, Viljoen & Kok, 2006). Mining companies created the Witwaters Native Labour Association which was a recruiting agency for migrant workers to work in mines. Bases of recruitment were set in over twelve countries where the recruits were taught [1]Fanagalo and basics of mining before immigrating into South Africa to work in the mines providing a source of cheap labour (Mawadza, 2008). The arrival of the British settlers in the 1820s also led partly to the emergency of Jewish community, which massively grew because of high influx into South Africa before and after the Second World War as a result of Nazi persecution in Germany (Dubb, 1991). Recent migration has seen increase of immigrants mostly from Africa because of increasing civil conflict and economic hardships experienced across the African continent and beyond. This has resulted in increased number of foreign migrants making South Africa their home temporarily and to some permanently and this influx of immigrants has resulted in the emergency of new forms of social behaviour of citizens against non-citizens in the form of attacks on immigrants and their property.

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The increased number of immigrants into South Africa, especially in the past decade has generated strong xenophobic attitudes and attacks in the country. Such attitudes are reflected in the provision of services in the health sector for example medical personnel manning the

[1] Fanagalo- it is a pidgin (simplified language) based on primarily Zulu with English and Afrikaans which was used by mainly immigrant workers in the mines.

public health care facilities exhibit negative attitudes and practices towards immigrant population by denying them access to health care even if they have valid identification papers. Xenophobia manifests itself within public institutions that should offer social services to all inclusive of immigrant population according to the laws of the country, policy and professional codes of ethics (Crush & Tawodzera 2011). Several factors contributed to the manifestation of xenophobia in both private and public institutions, for example South African media is relentlessly negative and blames immigrants for a variety of social and economic ills. One of the common xenophobic stereotypes in South Africa is that public institutions such as clinics and hospitals are swamped by foreign nationals who put unnecessary pressure on the already overburdened facilities such as the provision of ART. Evans (1995) made similar observations that immigrants are regarded as negatively affecting the health and welfare sectors of the country by using already depleted services, hence some South Africans feel that immigrants contribute to the depletion of state resources meant for citizens only. Immigrants have been blamed for incidents of increasing crime and prostitution which is a source of concern particularly due to its potential to increase the spreading of HIV and AIDS. Immigrants are also blamed for taking the jobs from South Africans by a large spectrum of South Africans. This provides insights into the connection of these changing discourses with the rise of social intolerances of immigration from other African countries.

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Most South Africans have negative attitudes towards foreigners based on the unfounded myths and stereotypes (Crush & Grant, 2007). The historical and social construction of illness resulted in refugee men being blamed for bringing diseases with them when they migrated to South Africa (Iboko, 2006). Health care workers do not appear to show interest in treating immigrant patients and those sick are mostly told to go back to their countries for treatment. Seidman (1998) argues that in social interaction, people accept the given claims about the realities of the world which will then be objectified into a certain view of the world. Consequently the view of the world become realised in the form of routine behaviour that is norms ,values , ethics and traditions which are implemented in the service provision at medical centres.

White paper on the transformation of health systems in South Africa (1997) states that there should be a priority for the provision of primary health care and make it available and accessible to all people including vulnerable and marginalised groups such as the poor, elderly, women, children and immigrants. The Western Cape Provisional Health Department also formulated its policies in line with the constitution and Department of Health. In its strategic plan 2010 it

states that there should be 'equal access to quality care' and upholding of core values such as integrity, honesty and respect for all the people.

Department of Health's failure to fully implement the policies on health care regarding non-nationals contributed to the immigrants' difficulties in accessing public health care. Department of Health issued a directive in September 2007 that refugees and asylum seekers, with or without documentation were eligible for free antiretroviral therapy (Robinson, 2005), but in fact the directive had not filtered down to the clerks, receptionists and nurses who deal with immigrant patients in public health institutions. Frontline staff in some hospitals and clinics did not seem to have any knowledge of the government's directive and this contributed to immigrants being denied access to antiretroviral therapy.

Immigrants without medical aid face more obstacles in accessing public health care than their South African counterparts without medical aid. Their biggest obstacle is that they do not possess a South African identity document which is a prerequisite for a smoother access to treatment. Immigrants with chronic illness that are debilitating tend to experience more difficulties in accessing public health care for example those with CD4 counts below 200 because of their non-citizenship have been denied access to antiretroviral therapy at some clinics which by law were supposed to provide them with the drugs whereas those citizens with CD4 counts below 200 have accessed the drugs without much of a hustle (Robinson, 2005).

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South Africans consider Western Cape as having improved health care system than any other province besides Gauteng Province, thus the tendency to relocate from other provinces to Western Cape. On the other hand national report for tourism and migration 2007 also shows that apart from Gauteng Province the large number of immigrants go to Western Cape. IOM (2011) provided a similar account that migrant populations, both internal and cross border, are largely concentrated in urban and peri-urban areas. The latest census conducted in 2011 revealed that Gauteng's population grew by thirty one percent and the Western Cape (whose main city is Cape Town) by twenty nine percent between 2001 and 2011. This increase is largely due to internal migration of South Africans from neighbouring provinces (such as Eastern Cape and Limpopo bordering Western Cape and Gauteng respectively) as well as cross border migrants to economic hubs. This is the background for the study which aims to investigate and examine the experiences immigrants go through in accessing public health care services in South Africa. The study focuses specifically on the Zimbabwean immigrants in Cape Town and the research problem is outlined below.

1.2 RESEARCH PROBLEM

Migration into South Africa by many nationals especially those from African countries and Zimbabweans in particular who have been described by (Mawadza, 2008) as one of the largest groups of immigrants in South Africa also influenced the undertaking of the study of investigating the experiences of Zimbabwean immigrants' access to public health care in Cape Town. According to (Vearey, 2010) Migrants tend to be stronger and healthier than the populations they leave behind, but despite this claim, migrants also face health-related problems after being settled in their host countries. Poor mental health is common due to social isolation, poverty loss of status and hostility from local population. For those already suffering from distress caused by persecution, torture and violence, those exacerbating factors can result in serious mental illness and suicide (Brill, 2004). Migrants are also often exposed to poor living conditions and more likely to be doing jobs that are strenuous and lack basic occupational safeguards and workers' rights (IPPR, 2006). Immigrants in South Africa just as much as immigrants in other countries are also affected by the same resulting in them being susceptible to sickness and needing the services of medical facilities which in most cases are public health facilities because of their poor economic status (Ama & Oucho 2008).

In South Africa free health care refers to health services that are rendered free at the point of contact at public sector clinics, community health centers and hospitals (Rispel, Palha de Sousa & Molomo 2009). The Constitution of South Africa, National Department of Health policy, codes of ethics from professional bodies and international conventions declarations which South Africa is a signatory such as Universal Declaration of Human Rights also outline how the immigrants in South Africa should be included in programmes such as free health care and should not be denied access to health care including ART with or without identification documentation. Contrary the experiences of some Zimbabwean immigrants at some public health care facilities indicated that immigrants experience difficulties in accessing public health care despite the presence of protective legislations, policies and international declarations. This motivated the need to conduct the study, considering what the laws and Policies of the South Africa stipulate and the experiences of the Zimbabwean immigrants at public health facilities. Given this and indeed other issues discussed in this section of the chapter, need arose to conduct a study of the experiences of Zimbabwean immigrants in accessing public health care in South Africa.

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1.3 AIM(S)

To investigate the experiences of Zimbabwean immigrants in accessing public health care after South Africa's attainment of independence in 1994.

1.4 RESEARCH QUESTION

The study endeavoured to answer the research question: What barriers do Zimbabwean immigrant patients face as they use public health care facilities in Cape Town?

1.5 OBJECTIVES

The objectives of the study are,

1. To establish the nature and scale of difficulties in accessing public health care experienced by Zimbabwean immigrants in Cape Town.
2. Identifying the disjuncture between policy and practice in the public health care service.
3. To examine the perceptions of medical personnel towards Zimbabwean immigrants.
4. To determine the extent of the use of public health facilities by Zimbabwean in Cape Town.

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1.6 DESIGN AND METHODOLOGY

The design of the study and the methodology are outlined briefly below and extensive discussion is in Chapter three. A mainly qualitative approach was used to investigate the Zimbabwean immigrants' access to public health care centres in Cape Town. The study was both descriptive as it described the obstacles that Zimbabwean immigrants faced in accessing public health care and explanatory as well, as it explains why the Zimbabwean immigrants experienced barriers and difficulties in accessing public health care.

Questionnaires were administered on both immigrants and medical personnel at the medical centers surveyed. Administering questionnaires on both the immigrants and medical personnel was prioritised so that the reasons for the difficulties in accessing public health care could be obtained from both sides that is the recipients as well as the providers of public health care. Difficulties in having access to the practitioners were experienced because of hectic schedules that most of them had, effort was put at least to get reaction from the practitioners to create a

balance. The questionnaires used had closed and open questions so that the respondents had chance to fully explain themselves and not to be restricted by closed questions.

Semi structured interviews were also used to access information from the immigrants this gave an informed insight in their experiences in using the public health care facilities and their backgrounds. Interviews were conducted after administering of questionnaires, reason being that of clarifying certain issues and aspects that were not clarified by responses from the questionnaire as there is a challenge when administering a questionnaire that respondents may leave blank spaces or put more than one response or that the available choices of responds would not suite them, so the interview was used to clarify these anomalies. Semi structured interviews on Zimbabwean immigrants had mainly five sections of questions that is biographical questions, their experiences when they were at public health care centres, the attitudes of medical personnel manning South Africa's public health care system and the government's efforts in providing social services to vulnerable immigrant population and whether South Africans in general are accommodative to immigrants.

1.6.1 RESEARCH PARTICIPANTS AND RESEARCH SETTING

The units of analysis for this research were individual Zimbabwean adult immigrants all above the age of eighteen who were sampled out of the immigrant population in Cape Town as well as the medical personnel that were sampled from four South African public health care centres which are,

- Kayamandi Clinic
- Kraaifontein Community Health Clinic
- Khayelitsha Site B Community Health Clinic
- Red Cross War Memorial Children's Hospital

The four public health care centres sampled were randomly sampled from a sampling frame of six public health centres that are dotted across Cape Town in places where the immigrant population mostly and refugees reside which are mostly informal settlements and high density areas. Six names that is two hospitals and four clinics were shuffled in hat and the first three clinics and one hospital to be drawn were selected.

1.6.2 SAMPLING

The study used probability random sampling for the medical personnel so as to attempt to be evenly representative of gender as well as ethnic differences and to be representative of the population being observed. Purposive sampling-snowballing in particular which is a non-probability sampling method was used to identify the Zimbabwean immigrants that used the public health care facilities, because the probability sampling methods may fail to pick up even one Zimbabwean immigrant, so it was significant to use purposive sampling which Bryman & Bell (2003) describe as sampling with a purpose which include people of interest and exclude those who do not suit the purpose. Effort was made to ensure that the sample had immigrants from varied backgrounds in terms of age, occupation, gender, legal status, aim was to identify a heterogeneous sample as possible.

1.6.3 DATA COLLECTION PROCEDURE

Access to the population was through personal delivery of the questionnaires to the various public clinics and hospital that were involved in the survey. Confidentiality of the participants was maintained with the questionnaires being kept anonymous. All the participants received a composite questionnaire including a cover letter giving the reasons for the survey and instructions on completing the questionnaire. For the Zimbabwean immigrants I asked the respondents to complete the questionnaire whilst I waited for them because it was difficult to possibly meet them again.

Interviews were conducted on thirty Zimbabwean immigrant patients. Convenient sampling method was employed to identify Zimbabwean immigrant patients who had at least used the public health care facilities.

1.6.4 DATA ANALYSIS

Qualitative content analysis of data was used. Data that was collected from different participants in the study and was grouped, tabulated and compared which resulted in the formation of the sub themes and main themes where meanings were derived and led to the emergency of new themes and categories. It is assumed that when classified in the same categories, words phrases and the like share the same meaning. The objective was to attain a condensed and broad description of the phenomena and the result of analysis is concepts, or categories describing phenomena (Cavanagh, 1997 in Hsieh & Shannon, 2005). Data from open-ended questions in the questionnaires was also qualitatively analysed using content

analysis just like the data from semi-structured interviews. The closed questions and the Likert-type rating questions that were in the questionnaires were statistically analysed using the Micro soft excel package of data assessment.

1.6.5 VERIFICATION OF DATA

The objective of a researcher is to produce research findings that are credible for the study to be trustworthy, this is mostly achievable when the data gathered is verified to determine accuracy (Lincoln & Guba, 1985). Reliability is another form of data verification method used in the study and has been described as the degree of consistency with which an instrument measures the attribute it is supposed to measure (Polit & Hungler, 1993). Three forms of validity were employed so as to maintain the accuracy of the data collected. The first was triangulation which is the use of several methods to explore the same issue, the study used questionnaires and interviews to explore the experiences of Zimbabweans immigrants at public health facilities, and Respondent validation was used in the study whereby the values of the researcher were not imposed on the participants. Unobtrusive measures were maintained in the study as the researcher minimised the disturbance of the scene so that respondents would act natural and would give honest natural responses not manipulated responses because of the presence of the researcher on the scene.

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1.7 RELEVANCE OF RESEARCH

There has not been much research that has been done regarding the social problems that Zimbabweans immigrants experienced in South Africa such as barriers to accessing public health care because, Zimbabwean immigrants were not on the spotlight due their circular migratory nature. Wentzel, Viljoen & Kok (2006) point out that Zimbabwean migrants exhibited circular movements between South Africa and their homes such as Zimbabwean women involved in cross-border trading would not stay for more than a month in South Africa before returning home. They did not intend to stay for long periods of time or settle permanently in South Africa (Wentzel et al, 2006).This resulted in most attention on immigrant population being put on other African immigrants from countries such as Mozambique, DRC, Somalia and Ethiopia.

HRW (2008), states that unlike previous migration between South Africa and Zimbabwe in which Zimbabweans migrated circularly for economic reasons and typically held work permits, The sharp deterioration of the political and economic situation in Zimbabwe in the year 2000,

the year in which farm invasions started forced many to leave their country in increased numbers and the subsequent movement of undocumented migrants between 2005 and 2008 had been motivated as well by persecutions, arbitrary arrests, detention, torture and beatings and government orchestrated violence. This led to unprecedented numbers of Zimbabweans to leave their country for other countries especially South Africa where Zimbabwean immigrants are estimated to be over two million. It was imperative to conduct the study because of its potential to contribute to the development of a dimension of studying Zimbabwean immigrants' social problems in particular considering Zimbabwean immigrants' status of having the highest number of immigrants in South Africa as well as the experiences of these immigrants at public health care centres in Cape Town at the backdrop of South African law which entitles people to a range of basic social services including access to free primary health care regardless of nationality or legal status.

1.8 ETHICAL CONSIDERATIONS

Immigrants' difficulties in accessing public health care is a sensitive discourse because of the emotional bearing it has towards the immigrants. Most immigrants would have experienced stressful encounters with the Department of Home Affairs officials in trying to acquire papers that legalise their stay in South Africa, when they fall sick, they face equally challenging experiences in the hands of medical personnel at public clinics and hospitals. On the other hand the health care workers were overburdened with their work load which was also made difficult by the unavailability of essential resources and equipment which they needed to conduct their work. The researcher was cautious and exhibited extraordinary humility and patience in order to exhibit respect for subjects 'dignity, moral values and legal rights.

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When conducting semi-structured interviews the subjects were informed of the nature and content of the study, they were asked whether they would consent to participate in the interview. They were assured that their opinions, views, and ideas were respected and strictly kept confidential and nothing was held against them regarding the interview responses they provided. They had the prerogative to freely withdraw from the interview and they were free to ask questions as well.

In the case of administering questionnaires of both the Zimbabwean immigrants and medical personnel, a cover page was attached to each questionnaire which explained the purpose of the study and their rights as participants. With the questionnaires of Zimbabwean immigrants verbal explanation was also done to complement written explanations on the cover sheet as the

questionnaires were completed whilst the researcher waited to collect the completed questionnaire from the participants. Clarification of the immigrants' medical condition was not required, only their experiences when accessing public health care were required for the study so confidentiality on their medical conditions was maintained.

Lastly I obtained ethical clearance from Senate Research Committee of University of Western the Cape following their required procedure.

1.9 DEFINITION OF TERMS

REFUGEES

The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as,

(a) " a person who as a result of a well-founded fear of being persecuted by reason of his or her race, tribe, religion, nationality, political opinion or membership of a particular social group, is outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country, or, not having a nationality and being outside the country of his or her formal habitual residence is unable or owing to such fear, unwilling to return to it, or (b) is a person who owing to external aggression, occupation or foreign domination or events seriously disturbing or disrupting public order either in part or the whole of his or her country of originality, is compelled to leave his or her place of habitual residence in order to seek refugee elsewhere.

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ASYLUM SEEKERS

Asylum seekers have been also defined by UNHCR as 'people who have applied for the refugee status and whose decisions are still pending'.

In South Africa there are many of these people because of the backlog of applicants whose applications have to be considered by The Department of Home Affairs (DHA) which is under resourced and under staffed, Thus why it takes up to five years for one to get or not get refugee status (Robinson, 2005).

INTERNATIONAL STUDENT

The Department of home affairs defines international students as non- South African persons admitted into South Africa for the specific purpose of following courses of study in an

accredited institution of higher Education (Ramphele 1999: 8). Students are required to have temporary resident permits (study permit) which are always checked at the start of each academic year before registration and this acts as way of making sure that students are legal in the country before they start their academic year.

ZIMBABWEAN IMMIGRANT

For the purposes of this study Zimbabwean immigrant does not mean each and every Zimbabwean in South Africa. Since people come from different backgrounds with different ethnicities and social classes, Zimbabwean immigrant refers to those vulnerable and marginalised immigrants, in most case black people who are either refugees, asylum seekers or undocumented immigrants, holders seasonal permits who do not have medical aid and cannot afford private health care, most of these people are either unemployed and survive on selling wares or are employed mostly in menial jobs which do not remunerate adequately and mostly reside in informal settlements, and this group excludes middle to upper class immigrants who use private health care.

CITIZEN AND NON-CITIZEN

For this thesis a citizen of South Africa is anybody holding a South African Identity document as a result of being a South African legally and resides in South Africa. A non-citizen is anybody in South Africa who is not South African citizen and does not possess the green identity book. (White paper on international migration 1999).

1.9.1 OVERVIEW OF THE STUDY

The study was composed of five chapters that endeavoured to illuminate the experiences of Zimbabwean immigrants at public health care centres in Cape Town after 1994, following the introductory chapter which gave a brief overview of the study, including the motivation, relevance and the context which the study was done leading to the inference of other studies and adoption of an insightful theory in the following chapter.

Reference to literature locating the study with other studies focussing on immigrants' access to health care was carried out, surveying, key literature that was pertinent and an insightful theoretical framework was developed setting a platform for the research methodology section.

An outline of the research methodology which incorporated the research design, sampling and data collection and analysis procedure was presented in this section leading to the findings and presentation of data in the next chapter.

The research findings and presentation are contained in this chapter and this assisted immensely in responding to research question proceeding to the discussion and recommendations in the next chapter.

The last chapter summed up the study by discussing the results, implications, recommendations and limitations of the study.

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CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

This chapter discusses empirical studies of immigrant access to health care and the theoretical explanations in this regard. The objective of the discussion is to locate the current study with others focussing on immigrants' access to health care as well as to establish an insightful theoretical framing for the current study. The discussion surveys key literature that is pertinent and does not claim to be exhaustive.

2.2 CROSS BORDER MIGRATION

The number of international migrants, including refugees, asylum seekers and undocumented migrants is on the increase worldwide (Hussein, 2003). The increase of the number of migrants has resulted in migration being described as one of the defining issues of the century. International Organisation for Migration estimates that they are nearly two hundred million people living outside their countries of birth. These migrants include generally voluntary migrants and forced migrants which are mainly refugees and asylum seekers. In most cases internally displaced people live in refugee camps, while unmet health needs of millions of people living in makeshift camps and varied places across the world are a public health challenge, this literature draws attention to the plight of migrants, refugees and asylum seekers to access to health care (UNHCR, 2007). It is noted by (Landau & Grant, 2007) that South Africa is the SADC member state with highest rates of internal and cross border migration. This phenomenon of receiving large numbers of people who come to seek refuge as a result of push factors that make them leave their own countries and pull factors that attract them to South Africa results in the increase in the numbers of immigrant arrivals (McDonald, 2000). White Paper on International migration (1999), stated that the continued arrivals of immigrants in their large numbers especially undocumented immigrants has negative impact on the provision of services and the South African society at large. It states that immigrants compete for scarce resources with millions of South Africans, living in poverty and below breadline; they also compete with residents and citizens for scarce public services, such as schools and medical care, infrastructure and housing and informal trading opportunities**.** This movement of people from their countries to host countries also involves both men and women of varied age groups as stated below.

Maguire (2011) points out that global migration of sports labour predominantly though not exclusively involves men, their ability to move over time and across space is based mainly on patriarchal structure. Dodson (2002) in the study of the cross-border migration from Lesotho, Mozambique and Zimbabwe to South Africa found that women are more likely to be subject to the will of a male that could be a

partner or parent in determining whether they will migrate. Todes (1998) reports similar findings in her study in Newcastle KwaZulu Natal where it was rare for women to experience freedom of movement than men did. Women's mobility varied according to their position in the household. Married women could not move at will, their husband's power in this regard was clearly apparent. Unmarried women were freer to move, but this depended on their position in the household, usually they were constrained by their roles as care givers, responsibility for children, and the sick, the disabled and old parents. In 2013 women comprised forty eight percent of all international migrants worldwide yet there were considerable difference across regions. In the south women accounted for forty three percent, the decline was primarily due to the result of increase in the number of male migrants in Asia who emigrated to oil producing countries of western Asia (International migration report, 2013).

On the other hand gender identities are characterized by fluidity, movement and transformation, Because of transnational migration, ideas about traditional and appropriate gender roles are rapidly shifting, and newly defined masculinities and femininities are evolving as a result of migration (UN-INSTRAW 2006). Women are increasingly migrating as the main economic providers for their households that is they migrate autonomously as breadwinners, a contribution that has served to increase their visibility within migratory flows proportions vary significantly by country, in South Africa women represent 42.7 per cent of the total cross border migration (UN-DESA 2010). This emerging wave of gender migration represents what Jansen, (1970) summarises in the seven laws of migration of Ravenstein in law number seven which says 'Females are more migratory than men'. Though gender of a person affects migration, age also plays a role in determination of migration as outlined below.

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In 2013 three quarters of all international migrants were between the ages of 20 and 64 and in the south the most migrants were between the ages of 25 and 34. This qualifies the assertion that it is mostly the economical active age group that is more migratory than the other age groups. In California undocumented immigrant men ages range from 18 to 64 and had the highest labour market participation than any group (Wallace, Toress, Nobari & Pourat, 2013).

Marital status has been found to have very different implications for both male and female migration. It has been observed that married women rarely migrate by themselves autonomously in contrast to married men, women who migrate internationally are slightly more likely to be married than male migrants (International migration report, 2013). Married women could not move at will, their husband's power in this regard was clearly apparent. Unmarried women were freer to move, but this depended on their position in the household, as mentioned before was constrained by their roles and responsibilities in the family. Level of education also affected the rate and gender of migration, though it differs from people to people and country to country, however there are more men in Africa than women who have tertiary education and this influences the number of movements based on gender lines. Ama & Oucho

(2008) observed that a lot of male immigrants in Botswana have higher levels of education and work skills that they possess hence they are likely to migrate more than women.

Separation of immigrants and refugees from their home countries relatives, members of their families, possessions, and traditional routines of behaving in their home countries makes them susceptible to sickness (Ama & Oucho 2008). In receiving countries newly arrived migrants have often been concentrated in poor low status regions of major cities where they usually live in less favourable and low standard living conditions which affect healthcare, Schippers ,Van Dongen, Dekker, Geertzen & Dekker (2006). Biswas, Kristiansen, Krasnik & Norredam (2011) writing on access to healthcare for undocumented migrants in Denmark explains that undocumented migrants and other new arrivals often reside in poor living conditions that may have negative health consequences.

People who migrate tend to be stronger and healthier than the populations they leave behind, despite this migrants also face health-related problems after being settled in their host countries. Poor mental health is commonly due to social isolation, poverty loss of status and hostility from local population. For those already suffering from distress caused by persecution, torture and violence, those exacerbating factors can result in serious mental illness and suicide. Migrants are also often exposed to poor living conditions and more likely to be doing jobs that are strenuous and lack basic occupational safeguards and workers' rights (IPPR, 2006). Migrants tend to experience poorer access to health care compared to the rest of the population. National health systems often discriminate against migrants and asylum-seekers in spite of several treaties (IPPR, 2006).

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2.3 CURRENT STATUS OF PROVISION OF PUBLIC HEALTH CARE SERVICES IN SOUTH AFRICA

The United Nations article 25, 1948 on the Universal Declaration of Human Rights states that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control'. United Nations expects every member state to implement this declaration and failure to do so will be a direct violation of human rights law and the United Nations law. The South African constitution according to (SAHRC, 2008) states that South Africa belongs to all who live in it without any reference to place of birth and or citizenship and everybody has the right to be treated with respect and dignity. In addition to this, South Africa has also ratified several international conventions such as, 1951 United Nations convention relating to the status of refugees, 1979 convention on the elimination of all forms of discrimination against women and 1989 convention on the rights of the child. Biswas et al (2011) mention that when a nation state ratifies these treaties, there are therefore legally bound by the mentioned treaty provisions, international human rights law recognises that a right to health benefits everyone residing in a state's territory. Thus undocumented

migrants have a right to health care on a non-discriminatory basis. Grove & Zwi (2006) and Amon & Todrys (2008), pointed out that the denial of health care services to cross-border migrants raises serious concerns, their resultant inability to access appropriate and timely care may ultimately place the host population at risk there by placing an even greater burden upon the health system that destination countries were trying to avoid. Landau, Ramjathan-Keogh & Singh, (2005) argue that although attitudes towards non- nationals especially black foreigners vary across South Africa's socio economic and ethnic spectrum, there is strong evidence that non-nationals living and or working in South Africa face discrimination at the hands of citizens, government officials, the police and private organisations contracted to manage their detention and deportation. This claim raises a significant point in the disjuncture in policy and practice characterised by lack of effective monitoring and evaluation system, as officials that are supposed to protect immigrants and not to discriminate them (Rispel et al, 2009).

The past couple of years has seen a growing consensus at the global level about need to address the difficulties associated with weak health systems in low and middle income countries (McIntyre & Gilson 2005). With the growing understanding of the importance of strong health systems to effective service delivery there has been a growing interest in health systems research. McIntyre & Gilson (2005:22) defines health systems research as " The multidisciplinary field of scientific investigations that studies how social factors, financing systems, organisational structures and processes, health technologies, and personal behaviours that affect access to health care…"This becomes paramount to this literature review as health systems research starts with a problem or topic that arises from practical policy or implementation experience, and selects methods, whether qualitative or quantitative that address this in the most appropriate manner. Organisational processes such as failure of service providers to implement what the policy entails, results in immigrants facing challenges in accessing social services such as health care. Bill of rights chapter 2 article 27 says 'no one may be refused emergency treatment' National health act 61 of 2003 chapter 2 article 5 says 'a health care provider, health worker or health establishment may not refuse a person emergency medical treatment'. This policy implies that anybody in a life threatening situation should not be denied treatment for whatever reasons. SAHRC (2004) observed an incident where a Somali woman who had pregnancy complications and was not attended by any hospital staff which resulted in her giving birth on the floor and after a couple of days the baby passed away. She was not helped because she had no South African identity document. Mupedziswa (2009) argues that while on paper South African constitution is inclusive in terms of access to social services, it would appear immigrants residing in that country seems to be sinking into the quicksand of a new brand of inequitable access to social services. Mupedziswa (2009) further explains that in pre 1994 apartheid system played out in the form of white citizens against fellow non-white citizens, in the post 1994 a form of apartheid appears to be presenting itself in the form of nationals versus non-nationals often irrespective of the citizenship status of the non-nationals, with the non-nationals on the receiving end.

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South African government supports international efforts to protect and assist refugees and asylum seekers in particular by providing them with access to health facilities, schools and social services as well as banking (Bidandi, 2014). Conversely one of the most basic rights that members of a society possess is the right to protect their financial security and economic safety by opening and maintaining a bank account (Bidandi, 2014). Refugees and asylum seekers in South Africa were explicitly denied this right up to 2010 as a result of the regulation of financial intelligence centre. Following a legal petition in 2010, a settlement was reached between financial intelligence centre and Department of Home Affairs for change of policy and Department of Home Affairs providing banks with ability to verify the authenticity of the permits. Despite these important developments many asylum seekers and refugees in South Africa still find it impossible to access basic banking services. Most of them reported being turned away at the banks. Bidandi (2014) mentions that banks such as Absa, Ned bank, Standard, and Capitec explicitly state that they do not open bank accounts for asylum seekers and refugees. This presents problems as they are in breach of national and international laws and human rights standards. Once again the issue of policy and practice comes into play. Policies are not implemented fully regardless of their existence and this has a direct bearing to the immigrant population in South Africa which is affected when accessing basic services which by law they are allowed to enjoy. Ama and Oucho (2008) described a situation where countries sign but thereafter fail to ratify these international instruments of human rights and even when they ratify the international instruments and pass national legislation, they do not enforce them. There exists therefore tension between international laws to protect human rights and national laws and countries' promotion of only the rights and welfare of their citizens. Rispel et al (2009) highlights a major weakness of most policies which is lack of monitoring and evaluation systems, with clear indicators that incorporate system responsiveness. Health inequalities must be measured, social policies must be carefully designed and effectively implemented, addressing the constraints identified, monitoring and evaluation systems need improvement and participation of communities needs to be encouraged through conducive and enabling environments (Rispel et al, 2009).

When refugees and asylum seekers visit community health care centers and public hospitals, they should produce their refugee statuses or asylum seeker papers, but having those papers in essence means nothing, staff at the registration points do not recognize the legitimacy of these identification documents because they have not been properly trained (Robinson, 2005). Policies that spell out how migrant populations should be treated are there, but what is lacking is mostly is the practice part of it. Under South African law, people regardless of nationality, or legal status are entitled to a range of basic social services including emergency medical treatment. All documented migrants are entitled to health care and education, refugees are also entitled to disability grants and social assistance under refugee relief fund. Despite those legal provisions few departments or public service providers have adequate practices relating to the inclusion of refugees, asylum seekers and migrants (CORMSA, 2008).

Shindondola, Dlamini, Esquirel & Sikakane (2001) made similar observations when they said in practice non-citizens, both with and without status are still marginalized in the provision of social security and the relevant minimum core benefits as provided in the law. Despite free emergency care and basic health care including antiretroviral therapy being available by law, documented and undocumented immigrants face challenges in accessing public health care (Harper & Raman 2008). Cross-border migrants face challenges in accessing public health care services despite the presents of protective legislation, identity documents cannot prevent discrimination or ensure social inclusion (Landau, 2007). Palitza (2008) observed cases were foreign nationals have been refused treatment in clinics by nurses and doctors who were not aware of the law. CORMSA (2008) reports that some of the public clinics and hospitals have continued to deny immigrants access to antiretroviral therapy despite the 2007 directive by the National Department of Health that the possession of a South African identity booklet is not a prerequisite for eligibility for antiretroviral therapy. South African health personnel are intolerant and having documentation is no guarantee to access to basic social services, thus being an immigrant in South Africa is related to having difficulties in accessing public health care.

2.4 BARRIERS TO PUBLIC HEALTH CARE AT PATIENT LEVEL

2.4.1 SOCIAL STRUCTURE VARIABLES

2.4.1.1 ECONOMIC STATUS

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In United States of America immigrants' access to health care differs from state to state, but there is a general trend that many immigrants have lower incomes and are less able to pay for care out of pocket. Hermer (2008) describes a situation that many patients who are not citizens due to their economic status lack private insurance or eligibility for public health coverage. They do not have private insurance because they cannot make the monthly contributions as a result of lack of enough income to do that. They also work in low paying jobs in the service sector that usually do not provide health benefits which results in them not being able to access health care because they cannot afford the costs.

Lessard & Ku (2003) state that the economic and unemployment status of many immigrants have implications for their children's health because of their inability to afford private health care. A disproportionate share of immigrant parents hold low wage, poor quality jobs that do not offer employer sponsored insurance coverage, so their families lack access to private insurance coverage. This usually results in immigrants failing to access quality health care mostly when they fall sick, due to their inability to access health insurance and many immigrants avoid or delay medical care because of financial burdens.

Lamb & Smith (2007) noted that the immigrants in New South Wales, Australia also fail to access private health care as a result of financial constraints that are almost universal for people who arrive as

humanitarian entrants who have yet to find employment. Most of them do not own cars and they use public transport which is expensive and this can influence their decisions about accessing health care. Cost can prevent referrals to services not covered by Medicare. The same applies to the use of private dentists, limited finances will deter them from using them and reliance on public dentist is problematic for them.

2.4.1.2 CULTURE

Cultural difference between the immigrants and the nationals of the host countries create barriers to access to health care. Mohanty (2002) is of the idea that contestations in terms of explaining a medical condition will arise as a result of different cultural belief systems. Berger and Luckmann (1998) in Gabe, Bury & Elston (2004) argue that social construction of illness stems from the social context from which all knowledge emerges. Oloyede (2002) in the essay 'mental illness in culture, culture in mental illness' discussed two contrasting views of mental illness, which are human universals and cultural particulars. He described how the Yoruba people connect illness in two broader views that is religious forces and social relationships. Oloyede (2002) gave an example of a sixteen year old girl who was taken to hospital and the seizure was diagnosed as epilepsy. The persistence of the seizure despite continuous medication convinced the parents to take her to a local healer who suggested that an evil spirit was responsible for illness. This contestation of world views may deter immigrants in mostly European countries from seeking medical care from hospitals but rather from medicine man because of the different cultural beliefs they subscribe to. Lin, Brown, Yu, Yang, Wang, Schrock, Bodomo, Yang, Yang, Nehl, Tucker & Wong (2014) also acknowledge that cultural differences may be a barrier to public health care, when they observed in Guangzhou and Guangdong provinces of China that African migrants who are traders experience the problems of language and cultural differences because the local health settings are not accustomed to the African migrant population.

2.4.1.3 LOCAL LANGUAGES

Scheppers et al (2006) also mentioned how lack of local language skills can act as a barrier to acquire effective health care, it prohibits the use of health services because it jeopardises effective communication between the ethnic minority patients and health care personnel. Most messages and instructions are communicated in the local languages, immigrant patients may feel embarrassed to seek out health care service, they may feel hindered because of their own ineptness at expressing their feelings due to language difficulties and reading ineptitudes, The inability to communicate in what is not their mother tongue inevitably leads to discrimination, due to lack of a common language they struggle to express their inner feelings, to ask questions, or to represent themselves. Language difficulties can have a detrimental effect upon the patient ability to comprehend proposed treatments and remedies, they also hamper the physician's attempts at obtaining vital medical history Scheppers at al (2006).

Languages that cross-border immigrants speak may act as barrier in accessing health care if they are not spoken by the host population. Cameron (2005) states that language barriers stem from lack of shared language between provider of health services and consumer. Siziba (2013) explains that language has emerged in South Africa as a boundary marking resource that profiles and excludes certain categories of people in this case immigrants who cannot speak local languages will find it difficult to navigate the terrain of accessing social services. Cameron (2005) argues that if there is no clear and effective communication during a health care session that enables both parties to understand the proceedings, then language proficiency acts as a barrier to accessing health care. She explains that language barriers can reduce the use of preventative services, increase time spent in consultation, testing, diagnosis and treatment, affects quality of service and decrease the probability of compliance with treatment.

Lessard & Ku (2003) mention that language barrier is also an impediment to access to health care in United States. They argued that immigrants who cannot speak English have difficulties in accessing health care. In a recent study of low income Latino immigrants and their children, they found that lack of English proficiency is an important risk factor for being uninsured. They found that low income non-citizen immigrants who primarily spoke Spanish were less likely to enrol for insurance coverage for their children or themselves than similar non-citizens who spoke English. Lamb & Smith (2007) mentions that English language proficiency does not play a part in selection of humanitarian entrance. This results in small and emerging refugee communities such as the Dinka people of southern Sudan to have language communication problems because of their native languages which are not spoken in host countries. Lamb & Smith (2007) further explain that while free telephone interpreter service exists for private medical practitioners many doctors are reluctant to use it which is another form of barrier to health care for immigrants. Lamb & Smith (2007) also mentions that studies of refugee populations in Australia, United Kingdom and in the United States show that language difficulties have in general practitioners surgeries have led to refugees being turned away. They also explain that Language barriers also result in miscommunications, misdiagnosis and lack of appropriate follow up.

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2.5 HEALTH BELIEFS AND ATTITUDE

2.5.1 PERCEPTION AND ATTITUDE TOWARDS HEALTH SERVICE AND PERSONNEL

Lack of familiarities with the host nation health care system may result in the immigrant population developing limited trust in the whole system as they would not be aware of how the system may assist them to access health care. Lamb & Smith (2007), state that many of the barriers to refugees accessing adequate care are similar to those experienced by the broader migrant community and other marginalised groups. These include reduced ability to trust service providers and to negotiate the health system. Lamb & Smith (2007) argue that people of refugee background often come from countries with

vastly different health systems which makes adaptation to new systems in host countries to be difficult. O'Donnell, Higgins, Chauhan & Mullen (2008) mention that unmet expectations are associated with decreased satisfaction which leads to immigrants not to be comfortable with the unfamiliar system.

2.6 PERSONAL ENABLING RESOURCES

2.6.1 IMMIGRATION STATUS

Immigration statuses as well as fear of being exposed to the immigration authorities and or the police also act as a barrier to access to health care for immigrants in fear of being exposed. Vearey (2010) explains that most SADC countries deport irregular or undocumented migrants when they are exposed. Vearey & Ritcher (2008) writes that irregular or undocumented migrants may encounter special vulnerabilities such as fear of deportation if they show themselves at health facilities for health service. Biswas et al (2011) point out that fear of undocumented immigrants of being reported to the police may cause delays in seeking treatment and encourage alternative health seeking strategies such as self-medication, contacting doctors in home country for advice or borrowing health insurance cards from locals. According to (Biswas et al, 2011) Danish health professionals believe that undocumented immigrants experience inequalities in accessing primary health care, and primary health care practitioners are uncertain of how to respond to this patient group. A recent study carried out by doctors of the world indicated that twenty nine percent of undocumented migrants in the Netherlands did not receive the medical services they needed. On the same note, the study found out that a number of general practitioners are unwilling to treat undocumented migrants and that undocumented children do not receive invitations for vaccination (Biswas et al, 2011). Hermer (2008) mentions that in United States general public is eligible for public insurance, but immigrant families are reluctant to enrol because of fear of jeopardising their families' immigration status. Children born in the United States by undocumented parents are eligible to receive emergency Medicaid and state children's health insurance program (SCHIP), but their parent do no enrol them for fear of exposing themselves to authorities and these children are denied access to health care. Their fear of deportation becomes greater than the fear of disease.

An immigrant's legal and social status can be defining in their access to reproductive health care. Undocumented migrants are put at a serious disadvantage in accessing health care services due to their legal status, just being an immigrant, even for those with documentation, can itself affect the accessibility of health services (Park 2011).

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2.6.2 BARRIERS AT PROVIDER LEVEL

2.6.2.1 SKILLS

Effective care may be impeded through health professional lacking skills to detect and manage unfamiliar disease among immigrants (Lamb & Smith, 2007). Lack of previous experience when dealing with relatively uncommon conditions by medical personnel may become a barrier to the provision of effective health care.

Generally, for those with intellectual disabilities, delays can result from insufficient provision of particular services, In Austria and Italy lack of suitably trained professionals in the area of psychology and psycho-therapy, as well as small number of multilingual professionals and the un availability of such services from one health insurance scheme to another resulted in some health care users experiencing long delays in accessing treatment, several users of health care facilities with intellectual disabilities reported being sent to three or four doctors for the same health problem. Low levels of awareness among health care professionals and lack of multilingual medical professionals can also result in difficulties obtaining a confirmed diagnosis and this causes barriers to receiving treatment (FRA, 2013).

2.6.2.2 BEHAVOIUR AND ATTITUDES

Cross border migrants continue to be portrayed as 'disease carriers' and viewed as placing an unnecessary burden on all social services in general and public health care systems in particular (Worth, 2006). Mead (1946) suggested that according to labelling theory people obtain labels from how others view their tendencies or behaviours. In this situation immigrants are seen as disease carriers and are often blamed by governments for introducing and spreading diseases (Harper & Raman, 2008). The resultant marginalisation of non-citizen groups has led to public health care becoming fused with 'politics of citizenship' in many cases, leading to the denial of health care to non-citizens (Grove & Zwi, 2006, Harper & Raman 2008). Siziba (2013) in the article language and identity negotiations: an analysis of the experiences of Zimbabweans migrants in Johannesburg, noted that language varieties constitute 'capital entry fees' in the main stream host society. Dumba & Chirisa (2010:16) in Siziba (2013) argue that "assimilation implies that immigrants adopted the language culture, values, and beliefs of the host society". This is the survival strategy that Zimbabwean immigrants negotiated and deviate from the standard norm by expounding the unmarked standard, which consequently legitimises their identity Siziba (2013), with the intention of accessing social services such as public health care without experiencing the challenges that they would have faced in their untransformed identities.

Sainsbury (2012) indicates that economists have advanced the idea of welfare states as a "magnet" for immigrants, they have raised the spectre that immigration may undermine the sustainability of welfare

states in advanced industrialised countries at the same time they may reshape the nature of competition in the labour markets to which those welfare states are attached. Similar observations have been made by Evans (2005) who says that concerns about the added burden of care and the draining of already depleted resources stemming from a general assumption that immigrants negatively affect the health and welfare of our society. The free health care policy has resulted in increased service use, particularly for preventive services, such as family planning and antenatal care (Rispel et al 2009). In South Africa, the general feeling among public health care professionals towards free healthcare policy was negative, and they were of the opinion that free health care had aggravated existing health service problems , such as poor working conditions, shortage of medicines, overcrowding and poor staff morale (Rispel et al 2009). Dodson (2002:1) quoted the former South African minister of home affairs Mangosuthu Bhuthelezi saying " if we as South Africans are going to compete for scarce resources with millions of aliens who are pouring into South Africa, then we can bid goodbye to our reconstruction and development programmes". It is also highlighted in the White paper on international migration (1999) that illegal aliens have negative impact on the provision of services, they compete for scarce resources with millions of South Africans living in poverty and below the bread line. The presents of immigrants in South Africa is viewed with different perceptions however the study showed that immigrants both legal and illegal are mostly viewed as causing extra burden to the already overburdened public health care. Dodson (2002) described South Africa as a highly xenophobic society, which out of fear of foreigners, does not naturally value the human rights of non-nationals. The resultant marginalization of non-citizens groups has led to health becoming fused with the politics of citizenship in many cases leading to the denial of health care to non-citizens (Harper & Raman 2008). Cross-border migrants continue to be portrayed as 'disease carriers' and viewed as an unnecessary burden upon public health systems of destination countries (Harper & Raman 2008). Immigrants are treated with contempt in South Africa and this makes it exceedingly difficult for foreign nationals in general and Zimbabwean immigrants in particular to access some of the basic services.

Lamb & Smith (2007) acknowledge that refugees settling in Western countries face many difficulties in accessing effective health care as documented by health service providers in resettled refugee population. Robinson (2005) made similar observations of refugees and asylum seekers who visited clinics and hospitals and were requested to produce their refugee papers as per procedure of identification but having that card in reality meant nothing as staff at the registration points did not recognize the papers. Brill (2004) also made similar claims that in effect healthcare is regarded nowadays as a fundamental human right, however when the focus is shifted from the literature on to the real health policy arena the supremacy of human rights of persons over social rights of citizens becomes less evident, this is when immigrants even if they have acceptable documentation they face difficulties in accessing services because of being foreigners. Mupedziswa (2009) supported the same claims of immigrant population having difficulties in accessing public healthcare with or without proper

documentation, on paper the South African constitution is inclusive in terms of accessing social services but it would appear forced migrants residing in that South Africa have been short charged as they seem to be sinking into the quick sand of an inequitable access to social service. Mupedziswa (2009) made a comparison of the pre 1994 apartheid played out in the form of white citizens against fellow non-white citizens and the post 1994 form of apartheid which appeared to be presenting in the form of nationals versus non-nationals often irrespective of citizenship status with the non-nationals on the receiving end. Having recognized documentation as an immigrant in South Africa is not a guarantee of having social services such as public healthcare.

Lamb & Smith (2007) further observed that hospitalization and other healthcare interaction that is not conducted in a sensitive manor… may retraumatize those under care, they further explain that racism and discrimination have been shown to reduce the access to healthcare in some marginalized groups and is likely to affect refugee groups as well. Jeff Radebe Minister in the Presidency visited day clinics on a fact finding mission and did get serious complains from patients who said the medical personnel had bad attitudes towards patients which is poor work ethics (Dano, 2015). Crush & Tawodzera (2011) discussed experiences of some immigrants who were called names or insulted by nurses who asked immigrant women why they came to have babies here in South Africa and should go back to their home countries and make babies there. Robinson (2005) expresses similar observation of immigrant patients' ill-treatment for instance when refugee and asylum seekers use clinics and hospitals they should produce their refugee permits but having those permits in reality means nothing because at registration points they do not recognize the legitimacy of their identification papers. This non-acceptance of non-nationals by South Africans has been described by Landau et al (2005) as varying across South Africa's socio economic and ethnic spectrum. They argued that non-nationals leaving and or working in South Africa face discrimination at the hands of citizens, government officials, police and private organizations that deal with foreign nationals. Immigrants are often denied full courses of prescribed medicines and have long waiting time Landau et al (2005). Landau (2007) explains that identity documents cannot prevent discrimination or ensure social inclusion. Palitza (2008) alludes with Landau (2007) that Zimbabweans who had South African identity documents written born in Zimbabwe were denied access to some healthcare programs because of them not being South Africans by birth, this pointed out that South African medical personnel were unaware of the policy on public healthcare for immigrants and refugees or did deliberately ignored the policy.

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Racial and cultural discrimination towards immigrants can also act as a barrier in access to health care services. Immigrants may have experiences in hospital or health care clinics where discrimination by health care professionals affect quality and efficiency of care, stereotypes of immigrants coming to United States to use up social services and take these services away from tax payers create a discriminatory stigma (Moss, 1996).This can have a negative effect on the immigrants experiences and further inhibit their ability to access health care.

2.6.3 COMMUNICATION

Communication can be a major barrier for immigrant patients to access public health care (Robinson, 2005). Robinson (2005) describes a situation where immigrant patients spent more than eight hours at some public health care facilities because of their mother tongue not being understood by those who are supposed to help them in the medical fraternity. Furthermore immigrant patients may face discrimination from health service providers who may also not speak their languages or understand their health history (IOM, 2010). Lamb & Smith (2007) argue that it is not only the absents of interpreter services that creates a barrier to the provision of public health care service to immigrant populations but the effective use of it as well. They gave an example of the Dinka people from South Sudan who are a minority in Australia who have been victims of non-use of interpreter services. They said while a free telephone interpreter service exists for medical practitioners many doctors are reluctant to use it. This non-use of interpreter service may create barriers of access to public health care to immigrants' patients who may need it as a last resort so that they may be afforded effective public health care services.

2.6.4. BARRIERS AT SYSTEM LEVEL

2.6.4.1 ORGANISATIONAL FACTORS

2.6.4.1.1 REFERAL SYSTEM

Asylum seekers and refugees have different expectations of health care. Unfamiliarity of the referral system including a lack of awareness of appointment system results in unmet expectations associated with deceased satisfaction. Previous knowledge and expectations of health care in their countries of origin has an impact on their expectations on general practice (O'Donnell, 2008). All the factors mentioned contribute to immigrants experiencing barriers to health.

2.6.5 XENOPHOBIA

As Landau et al (2005) observed the existence of hostile attitudes towards non-nationals by the nationals the same may be said for medical personnel, they may exhibit some xenophobic tendencies like some South Africans do and deny Zimbabwean immigrants access to healthcare. Harper & Raman (2008) argue that these perceptions of locals towards immigrants contribute to the challenges that immigrants experience when they need to access public health care.

Despite being a strong economy in Africa, South Africa faces challenges of unemployment, poverty and economic inequality which put refugees and asylum-seekers in direct competition with host poor population (Crush & Grant, 2007). This results in the creation of a situation of social exclusion whereby the immigrants are denied access to public health care Landau (2007:15) argues that "identity documents cannot prevent discrimination or ensure social inclusion" CORMSA (2008) in its annual

report cited a nursing sister who said that some of the immigrants from Zimbabwe who are now permanent residence of South Africa have been denied treatment in some hospitals because they have identity documents written born in Zimbabwe and that they only accept those of people born in South Africa. In reality it is noted that immigrants despite having valid permits or visas, there is no guarantee of having the same access to services and opportunities as South Africans. Although the constitution says everyone is equal, engagement of people within institutions that are meant to provide immigrants with services shows that immigrants are sometimes victims of vicious circle.

2.6.6 NATIONAL GOVERNMENTS RESTRICTIONS

National governments of host countries may put in place unfavourable policies to immigrants in form of restrictions to access to health care with the idea of protecting tax payer's money which creates a barrier for immigrants' access to health care. Biswas et al (2011) writing on the Netherlands entitlements and access to health care for immigrants, explains that the Dutch health care requires all residents to purchase private health insurance. Undocumented migrants however have been excluded from health insurance since 1998. In United States of America, federal laws prohibit immigrants from participating in programmes such as the state children's health insurance programme. Hermer (2008) explains that the personal responsibility and work opportunity reconciliation act of 1996 bars legal immigrants from participating in public benefits including Medicaid for the first five years of their residence in United States. Hermer (2008) further explains that it prohibits sponsored immigrants from participating for at least twice as long and it excludes undocumented immigrants from participating from nearly all federal funded benefits, in addition to challenges that immigrants face in accessing health care, when legal immigrants become eligible to receive federal benefits after five years of residing in United States other rules interfere with their access to benefits including previously stated health insurance.

Flores, Abreu & Tomany-Korman (2006) mention that several studies have consistently shown that lack of United States citizenship for the children and or their caretakers is a barrier for adequate health care access among Hispanic children. Personal Responsibility and Work Opportunity Reconciliation act of 1996 restricted Medicaid eligibility for non – United States citizens including individuals who have been United States residence for less than five years. The 2005 Deficit Reduction Act called for rigorous citizenship verification via birth certificate or passport, a policy that represents a barrier not only for undocumented or recent immigrants but also authorised immigrants who may not have easy access to these documents (Hermer, 2008). The restrictions that host countries put act in themselves as barriers to access to health care for immigrants, thus Sainsbury (2012) argues that all welfare states protect immigrants to a considerably lower degree compared to citizens.

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2.6.7 THEORETICAL FRAME WORK

The theoretical framework of this study was premised on Foucault's theory on power and its ability to explain the everyday practices of power between people and institutions. Foucault asserts that power is more a strategy than a possession, it is co-extensive with resistance as a productive factor because it has positive effects such as the individual's self-making and because as a condition of possibility for any relation it is ubiquitous, being found in any type of relation between members of society. Foucault (1980) indicated that individuals are always in a position of simultaneously undergoing and exercising power in their different positions in a local social context. Foucault's theory was preferred because of its ability to explain everyday practices on provision and accessing of public health care between the Zimbabwean immigrant patients and public health care institutions with the aim of illuminating the different positions that individuals and institutions occupy in provision and accessing of public health care. Foucault's understandings of power were important in unpacking and explaining the reasons for encountering difficulties that Zimbabwean immigrant patients experienced when accessing public health care services at various public health care facilities in Cape Town. Foucault' work was significant in exposing the presentation of power and the actual functioning of power in accessing or failure to access public health care services.

Foucault parted ways with the Marxists interpretations of power relations, arguing that power is not something that institution possess and use oppressively against individuals groups. Foucault moves a step further by explaining how power operates in day to day interactions between people and institutions. Foucault (1980) explains that the fundamental ideas emerging from these works is the privileged place to observe power in action, is the relations between the individual and society especially its institutions. Consequently Foucault studied what he calls analysis of power that is how the various institutions exert their power on groups and individuals and how the latter affirm their own identity and resistance to the effects of power. This study premises itself very well with Foucault's assertions on power relations as experiences of Zimbabwean immigrant patients at various public health care facilities in Cape Town resemble what Foucault describes as the privileged place to observe the power in action, is the relations between the individual and society, especially its institutions. This manifested itself in the study as the individuals which are Zimbabwean immigrant patients accessing public health care services at Clinics and Hospitals which are society's institutions and this study's aims to illuminate how power relations manifest themselves between individuals and society's institutions as Foucault' power theory suggests.

While for theorists like Althusser who studied and portrayed individuals to be just puppets of the ideological repressive apparatus of power by the state institutions where power acts from top downwards, Foucault proposes an alternative approach in which power relations dissipate through all relational structures of the society. This enabled him to build a model of the daily and mundane manners

in which power is exerted and contested, as well as an analysis centered on the human individual as an active subject, not as a simple object for power (Rabinow, 1991). In the study and the other literature used, it is clear that the immigrant patient were no just puppets of the medical institutions but also active participants of power relations as they showed resistance and in Foucault's ideas it was power dissipating through relational structure of society.

Foucault (1998) argues that we must overcome the idea that power is oppression, because even in the most radical form, oppressive measures are not just repression and censorship, but productive as they cause new behaviour to emerge. Foucault (1991) also argues that power is a major source of social discipline and conformity, this assertion was derived from surveillance and assessment in social service such as schools, prisons and mental hospitals which no longer required force or violence as people discipline themselves and act in expected ways. Foucault stresses that the effects of disciplinary pressure, initially imposed externally lead to self-discipline for the individual and eventually to the production of the individual himself as subject. According to Foucault the most important feature was the productive nature of power. His main aim was to turn the negative conception upside and attribute the production of concepts, ideas and the structures of institutions to the circulation and exercise of power in modern forms (Foucault, 1991) These views by Foucault can be attributed to the experiences of the immigrant patients who had to conform to the requirements of medical institutions to be granted access to services. Foucault referred to this form of power as disciplinary power that ensured conformity, but was productive as immigrant patients exercised power of changing their behaviours to be able to access public health care.

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Power produces, it produces reality, it produces domains of objects and rituals of truth, the individual and the knowledge that may be gained of him belongs to such a production. Institutions use various types of power enforcement with specific mechanisms and techniques, and Foucault shows how the clinic, hospital, prison and university share some of these disciplinary techniques and practices for power enforcement (Foucault, 1991) Specific mechanism and techniques were employed by the medical institutions that provide public health care to control all the patients that make use of their facilities including additional mechanism and techniques that were used for immigrant population that resulted in them experiencing barriers in accessing public health care.

Foucault is of the view that power is diffuse rather than concentrated hence it is found in any kind of relationship and all the relations between subjects are power related and there is an interconnectedness between power relation and action (Foucault, 1998). According to Foucault in every human interaction, power is subject to negotiation, each individual having his place in the hierarchy, no matter how flexible it would be. Foucault's theory offered an alternative explanation on the access to public health care by immigrant patients as a result of different forms of power relational structures between them and providers of public health care. When immigrants used public health care facilities they experienced

difficulties in accessing services as they confronted locals manning the public health care centers who used power to withhold services and could influence the way in which these services were delivered. However according to Foucault their behaviour was not only oppressive, but it was productive as lack of access also caused new behaviours to emerge.

Knowledge is inextricably entwined with relations of power and advances in knowledge are associated with advances and developments in the exercising of power (Foucault, 1980), Foucault described power as being closely related to knowledge and that a site where power is exercised is a place where knowledge is produced. According to Foucault power and knowledge are mutually dependent. This assertion applies in the interaction between the immigrant patients and providers of public health care, as the knowledge that the providers of public health care have regarding policy on immigrants access to health care affords them power to arrive at decisions that they made regarding immigrants access to public health care. On the other hand the knowledge that immigrant patients had upon their legal access to health care, also afforded them power to seek public health care though other factors come into play of whether they will be able to successfully access it or not.

Foucault's theory on knowledge and power assisted in unpacking the power relations that manifested themselves in the everyday practices between users of public health care system with particular attention to immigrant patients and the institutions that provide public health care. The theory exposes how various institutions exert power on groups or individuals and how the individuals affirm their own identity and resistance as active subject to the effects of power.

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CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The research literature surveyed in the second chapter provided varied immigrants' experiences in accessing public health care services in different developing and developed countries in the world. Focus on these studies was mainly on all immigrants in general inclusive of regular, irregular and refugees. This study's main focus was to investigate the experiences and the perceptions of Zimbabwean immigrants when they used public health care facilities in Cape Town. The Zimbabwean immigrants from the definition in chapter one were those vulnerable ones who were asylum seekers, traders, low skilled and undocumented ones. The research intended to highlight the Zimbabwean immigrant experiences and their perceptions as they interacted with mainly South African medical personnel that manned the public health facilities in South Africa.

A descriptive survey was utilised to best serve the project's purpose Powell (1997) describes descriptive survey as systematic and in-depth investigation of the population under study that allows a generalization from a smaller subgroup to a larger group, however the study of a group of Zimbabwean immigrants in Cape Town alone cannot statistically be used to refer to all the Zimbabwean immigrants in South Africa, but will offer a valuable insight to the larger context. This chapter focuses on the methodology that was used to illuminate the experiences of Zimbabwean immigrants as they utilise public health care facilities in Cape Town.

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3.2 RESEARCH DESIGN

The research study was mainly qualitative, O'Connor & Gibson (2005) describes qualitative analysis as more concerned with meaning, and data is a word which describes valid information that can assist the researcher from answering questions. The study essentially involved questionnaires that were complimented with semi-structured interviews of Zimbabwean immigrants in Cape Town that made use of public health care facilities. A descriptive survey was selected because it was convenient for this research as it allowed for the aims of the study to be better captured by establishing and finding out what the researcher intended to investigate. A survey obtains information from a sample of people by means of self-report that is people respond to a series of questions posed by the investigator (Polit & Hungler, 1993). In the provision of social services, descriptive surveys are used to extensively understand attitudes, characteristics and perceptions of respondents (Powell, 1997). This is mainly the reason why the researcher opted for the use of descriptive surveys in this study.

3.3 RESEARCH SETTING

The study was conducted at Kayamandi clinic which falls under the Stellenbosch Health District of the West Coast - Boland, Khayelitsha Site B Community Health Clinic which falls under Khayelitsha Health District of the Metro Region, Kraaifontein Community Health Clinic which operates in Oostenberg Health District of the Metro Region and Red Cross War Memorial Children's Hospital in Mowbray which caters mostly for children. These facilities are also used by immigrant populations that reside in high density areas of Kayamandi, Khayelitsha, Kraaifontein, and Mowbray which is a place with high immigrant population. Immigrants from the neighbouring residential places also make use of these facilities.

3.4 RESEARCH PARTICIPANTS

A sample population contains all the elements that meet the criteria for inclusion in the study (Burns & Grove, 2003). This study population consisted of adult Zimbabwean immigrants in Cape Town that had used the public health facilities in Cape Town and the medical personnel that worked in different Departments at the public health facilities that were used by the Zimbabwean immigrants whenever they required to make use of public health services.

3.4.1 SAMPLING

Probability sampling is sampling in which each element of a population has an opportunity of being selected for the sample, its purpose is to obtain a sample that is representative of the population and from which generalisations to the population can be made (Miller-Keane, 2003).The study used probability random sampling in selecting the medical personnel with the intension of being representative in terms characteristics such as gender as well as ethnic differences that these people have as well as to be representative of the entire population being observed. Purposive sampling which is a non-probability sampling method was used to identify the Zimbabwean immigrants that used the public health care facilities, because if a probability random sampling method was used chances were extremely high of failing to pick Zimbabwean immigrants which are the main research participants of the study, it was imperative then to use purposive sampling which Bryman & Bell (2003) describe as sampling with a purpose which include people of interest and exclude those who do not suit the purpose. This sampling method allowed a greater degree of control in selecting key informants. However effort was made to ensure that the sample had immigrants from varied backgrounds in terms of age, occupation, gender, legal status, aim was to identify a heterogeneous sample as possible.

A sample of ninety participants in total were selected for the study. The first thirty Zimbabwean immigrants that have used public health care facilities in Cape Town were purposively sampled for questionnaires and the other thirty were also purposively sampled for interviews. The Zimbabwean immigrant participants were all identified by the researcher at the selected public health facilities. Thirty

participants from the public health personnel were also randomly selected at the facilities where they offered health care services to both citizens and non-citizens.

3.5 DATA COLLECTION

When using descriptive survey method research participants answer questions administered through interviews and questionnaires, after participants answer the questions, researchers describe the responses given (Jackson, 2009). In this study semi structured interviews and questionnaires were the two data collection techniques that were selected because of their ability to collect the data that the researcher required for the study.

3.5.1 Data collection instruments

3.5.1.1 The Questionnaire

Having selected the survey and the sampling method it was incumbent for the researcher to select a technique that would collect the necessary data. A questionnaire was selected as a data collecting instrument. It is a printed self-report form designed to elicit information that can be obtained through the written responses of subjects (Burns & Grove, 2003). The questionnaire is the single most common research tool used in social sciences (Mouton, 2001). It was selected to evaluate the experiences and perception of Zimbabwean immigrants in accessing public health care as well as to evaluate the perceptions and attitudes of medical staff manning public health care facilities towards immigrant population, because of an array of advantages it possesses.

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Questionnaires are simple versatile and cost effective, they can reach a sample in a short space of time, they are designed in way that data is easy to collect and analyse, respondents can complete the questionnaire in their own free time, they ensure a high response rate as they are distributed to respondents to complete and collected by the researcher, Respondents can give frank and anonymous answers without feeling intimidated.

On the other hand they also have their own disadvantages such as the subjects might not reflect their true opinions but may answer what pleases the researcher and valuable information will be lost. They lack personal contact with the respondents in order to make it possible for the researcher to gain sufficient knowledge about participants in the study (Powell, 1997). Poorly designed questions may cause antagonism.

Two sets of questionnaires were used to collect data. The first questionnaire was for Zimbabwean immigrants that used public health care facilities in Cape Town and the second one was for the medical personnel that worked at the public health facilities which were utilised by Zimbabwean immigrants. The questionnaires consisted of mostly of closed questions which had predetermined responses provided by the researcher, however they also contained open ended questions that required the

participant to write in their responses (Burns & Grove, 2003). Open-ended questions allowed the respondents to express themselves without restrictions and in doing so provided a more detailed account of their experiences. Closed questions besides their restrictive nature they also provide a basis for efficient administration and analysis of data. Their efficiency is also realised when respondents are able to complete more closed questions than open questions in a given time period (Powell, 1997).

3.5.1.2 Questionnaire design

The questionnaires are provided in Appendix D and E respectively. The questions in the questionnaires are mainly quantitative, but the questionnaires also contain open-ended question that add depth to quantitative data. The mix of the questions aimed at gathering information on perceptions, opinions, and attitudes of medical personnel and the experiences of Zimbabwean immigrants when they interacted with medical personnel at the public health facilities. The Zimbabwean immigrants' questionnaire contained twenty closed questions, nine open ended questions and eight Likert-type rating scale questions. The medical personnel questionnaire contained nine closed questions, six open-ended questions and ten Likert-type rating scale questions.

Both the questionnaires had basically three sections that collected specific data for the study. The questionnaire for the Zimbabwean immigrants had questions one to nine which collected mainly biographical information such as age, gender, educational attainments, place of residence, year they came to South Africa and the reasons for coming to South Africa. This information was vital for assisting the researcher to interpret the findings as biographical factors could have influenced the experiences of the Zimbabwean immigrants. Questions ten to eighteen aimed at determining the experiences of the Zimbabwean immigrant patients at the public health care facilities such as whether they were asked to provide proof of residence to be assisted, or they were asked to make payments. Questions nineteen to thirty seven also aimed at acquiring policy related information, the attitudes of medical personnel towards immigrant patients and some general information on perception on whether South African government is doing enough to cater for the needs of immigrants especially the vulnerable ones.

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The questionnaire for the medical personnel also had questions one to ten that asked biographical question such as he age, gender, ethnicity appointment of the medical personnel, on job experience, languages they speak and their places of residence. Questions eleven to eighteen, aimed at determining the medical personnel encounters with immigrant patients such as whether they had at any time sent an immigrant patient away without attending to them, how do they assist immigrant persons who cannot speak English or any other South African language and whether they offered preferential treatment to patients that are citizens over immigrant patients. Questions nineteen to twenty five were about the medical personnel's knowledge about health policy towards immigrant as well their perception on

government's intervention to assist immigrants and its ability to provide resources needed for the public health care sector.

3.5.1.3 Interviews

An interview is a process in which a researcher and participant engage in a verbal conversation focused on the questions related to the research study (DeMarrais, 2004). This study focused on the person to person encounter in which the information was elicited verbatim from the participant by the researcher. Semi structured interviews were selected as a data collecting instrument so that information on the experiences of Zimbabwean immigrants in Cape Town would be obtained verbally from the participants.

Researchers conduct interviews so that they would find out from their subjects things that cannot be directly observed (Patton, 2002). People cannot observe the inner being of a person which could be feelings, thoughts and intentions. Previous participant behaviours cannot be observed as well as a result of time lapse. The purpose of an interview then was to allow the researcher to verbally bring out the subject's perspective. Interviews tap into the depths of reality of the situation and discover subject's meanings and understandings (Woods, 2006), it is therefore essential for the researcher to have empathy with interviewees and win their confidence (Woods, 2006).

An interview guide for the semi-structured interview was used as an aid, questions were more on the open ended side than closed and more in line with issues to be explored as specific data is usually required from subjects, for a specified study. The questions were all asked in any order that followed the way the interviewee was responding.

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3.5.2 Data collection procedure

Access to the medical personnel was through personal delivery of the questionnaires to the various public clinics and hospital that were involved in the survey. Confidentiality of the participants was maintained with the questionnaires being kept anonymous. All the participants received a composite questionnaire including a cover page giving the reasons for the survey and instructions on completing the questionnaire. Envelopes were also supplied with questionnaires such that when the participant had finished completing the questionnaire he or she would enclose the completed questionnaire in an envelope, seal it and hand it over to their reception. A period of fourteen days was made available for the medical personnel to complete their questionnaires and hand them in at their reception. For the Zimbabwean immigrants I asked the respondents to complete the questionnaire whilst I waited for them because it was difficult to possibly meet them again so that I would collect the questionnaire. The Zimbabwean immigrants were asked to spare about twenty minutes of their time as it took plus or minus twenty minutes for an average person to complete the questionnaire and hand it over to the researcher.

Thirty interviews were conducted on another set of Zimbabwean immigrant patients who had not participated in completing the questionnaire. Non-probability sampling method of convenient sampling was used to select the Zimbabwean immigrant patients that had utilised public health care facilities in Cape Town. The researcher asked for time from the participants to conduct the interviews, duration of the interviews varied from about thirty minutes to one and half hours for participants to answer the interview questions while the researcher took down the responses in a note book for analysis later.

3.5.2.1 Researcher Effects

All the participants in the interviews were Zimbabwean immigrants that were purposefully selected for this study. They all could understand chiShona so the interviews were done using a combination of both chiShona and English for the convenience of participants who preferred to use chiShona. The fact that immigrants could identify the researcher as a Zimbabwean immigrant helped to open them up as they took me to be part of them and not an outsider. Use of chiShona also helped the immigrants to express their inner feelings and how they felt about the public health care system in South Africa. Time factor, may be did influence some interviewees as they participated in an activity that they would not have set time aside for, but the fact that they all voluntarily participated after I had asked them for their time should have minimized time factor influence on quality of data collected.

3.5.3 VERIFICATION OF DATA

3.5.3.1 Reliability

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It is the degree of consistency with which an instrument measures the attributes it is supposed to measure (Polit & Hungler, 1993). The questionnaires used in the study demonstrated this phenomenon as there was consistency in the responses that were given by the respondents even if the questionnaires would have been administered to two different respondents for say between periods of two weeks. Reliability can be maintained by reducing the probability of measurement error such as data collection bias. This data collection bias was minimised in the study as the researcher was the sole person who administered questionnaires to both Zimbabwean immigrants and the medical personnel, for the Zimbabwean immigrant patients who had to complete the questionnaire and give it back to the researcher after completion the same day, the researcher maintained the same conditions of explaining the reasons of carrying out the research and the rights of the participants as were explained as well as the questionnaires were conducted under the same friendly relaxed and ambient environments though not at the same medical facility.

3.5.3.2 Validity

It refers to the extent at which an instrument represents the factors under study. Woods (2006) describes validity as having three dimensions which are unobtrusive measures, respondent validation and triangulation. **Unobtrusive dimension** is the less the researcher disturbs the scene, the longer spent in it, and the deeper the penetration of the research, the more the presentation of it might be claimed to be authentic. Subjects do not do things differently because the researcher is there, they do as always (Woods, 2006). In this study the researcher also tried to be as natural as possible so that the subjects would not would not play up to the researcher but do this normally.

Respondent validation is when researcher aims to understand the meanings and perspective of those being studied, how better to judge if our understandings are accurate and full than giving our accounts back to those involved and asking them to judge Woods (2006). Subjects may see the research primarily as either aiding or damaging their interests and respond accordingly. In this study subjects were not asked leading questions, the researcher was neutral and refrained from imposing any forms of personal values to the participants.

According to Woods (2006), **triangulation** is the use of several methods to explore the same issue which increases the chances of depth and accuracy of the findings. In this study methodological triangulation was employed when questionnaires were used to collect data from Zimbabwean immigrant patients and interviews were also carried out to collect data from the Zimbabwean immigrant participants, this aided depth and accuracy to the research findings as two different methods of data collection tools were used to investigate basically the same thing with the aim of getting convergent evidence from different sources that is the experiences of Zimbabwean immigrant patients as they used the public health care facilities in Cape Town.

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3.6 ETHICAL CONSIDERATION

The ethical considerations of the study were strictly followed, ethics are typically associated with morality (Babbie, 1998), for a research to be considered as a scientific inquiry it has to conform to ethical principles (Babbie, 1998).

Voluntary participation of all participants was strongly maintained. Social Science often though not always represent intrusion into people's lives. It often requires that people reveal personal information sometimes unknown to friends and associates and it requires that such information should be revealed to strangers (Babbie, 1998). In this case voluntary participation was required, emphasised and maintained.

Respect for the dignity and moral and legal rights was also another important focus of the ethical consideration in the study. The study involved Zimbabwean immigrants who were also vulnerable, and marginalised just like many other immigrants in South Africa. The researcher demonstrated high levels

of humility through his actions, language and interaction, with neutrality and tolerance were driving principles of the researcher so as to refrain from imposing personal values to participants.

The researcher also guarded against any possible harm that the study could impose on the participants. A research should never harm the participants regardless they volunteered to participate (Babbie, 1998). Information that could harm their relationships, jobs and association as well as information that could possibly cause psychological harm was avoided. Wassenaar (2006) subscribes to the same notion that no harm shall befall research participants as a direct or indirect consequent. In the case that information was collected, it was kept as highly confidential information and could not be released.

Ethical principle of self-determination and informed consent were applied and maintained research participants were treated as heterogeneous and autonomous agents by informing them about the study allowing them to voluntarily have a choice of participation or not. The participants were also made aware that they could refuse to answer questions that they were not comfortable with and they could withdraw anytime without any consequences to them (Babbie, 1998).

Anonymity and confidentiality were applied and maintained in the study. Anonymity is when the subject cannot be linked even by the researcher with the individual responses they provide (Burns & Grove, 2003). In this study questionnaires for medical personnel were only identified by the researcher with codes after collection and not with the names of the respondents as participant were informed not to write their names down. When the researcher conducted the questionnaires and interviews on Zimbabwean immigrant patients he got in contact with the participants, however for ethical purposes and privacy the researcher applied the ethical principle of confidentiality which according to (Polit & Hungler, 1993) is the process were the information provided by the participants will not be publicly reported in a way which identifies them.

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Lastly I obtained ethical clearance from Senate Research Committee at University Of Western the Cape following their required procedure. (Appendix C).

3.7 PROCEDURE

Permission to conduct the research at selected public health care facilities in Cape Town was sought from the Department of Health Western Cape. Permission was granted by Deputy Director General, District Health Services and Programmes **(Ref: 19/18/RP104/2009)** Appendix A to conduct research at Kayamandi Clinic, Khayelitsha Site B Community Health Clinic and Kraaifontein Community Health Clinic. Permission to conduct research at Red Cross War Memorial Children's Hospital was granted by the Senior Medical Superintendent **(Ref: RESEARCH)** contained in appendix B. Ethical approval of the methodology used and ethical consideration for the human research participants that were involved in the study was granted by Senate Research Committee of University of the Western Cape **(Ref: 09/8/6)** contained in Appendix C.

Consent of participants was obtained verbally from participants before completing the questionnaire and before interviews in terms of Zimbabwean immigrants. Medical personnel consent was sought through a written cover page that was on top of the questionnaire, which explained their free will to participate and complete the questionnaire or decline to complete.

3.8 DATA ANALYSIS

Analysis of data is a process of making sense out of data (Merriam, 2009). In the study data was collected, organised and analysed mainly qualitatively using content analysis which was described by Polit & Hungler (1993) as the process of analysing verbal or written communications in a systematic way, Patton (2002) describes content analysis as any qualitative data reduction and sense making effort that takes a volume of qualitative material and attempts to identify core consistencies and meaning. In the study, two descriptive survey methods of data collection were used to collect data. Semi-structured interviews were employed to collect data which was analysed qualitatively using content analysis, because of the nature of the questions that were open-ended and offered the participants room to express their feelings, perceptions, and experiences differently. Data was grouped and tabulated into themes and meanings that the researcher identified and analysed. Data from open-ended questions in the questionnaires was also qualitatively analysed using content analysis just like the data from semi-structured interviews. The closed questions and the Likert-type rating questions that were in the questionnaires were statistically analysed using the Micro soft excel package of data assessment were descriptive statistics were presented in the form of tables, pie diagrams and histograms.

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3.8.1 QUALITATIVE CONTENT ANALYSIS

Qualitative content analysis has been defined by Patton (2002:453) as 'any qualitative data reduction and sense making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings'. Content analysis is more than just counting words or taking objective content from text to examine patterns and themes that are found in a particular text. It allows social science researchers to fully understand social reality in a subjective but scientific way. It is related to research question as it explains the texts from the subjects in so doing offering possible reasons that may respond to research question. Qualitative content analysis gives significance to salient themes that gives meaning to the social world rather than the statistical importance of occurrence of a particular concept. It involves a process designed to condense raw data into categories and themes which are based on interpretation.

Content analysis has different forms, three of them which are conventional, directed and summative qualitative content analysis approaches were discussed by (Marying, 2000). Conventional qualitative content analysis was described as the process of coding categories derived directly from the raw data that the researcher would have collected and transcribed. Directed qualitative content analysis was describe as analysis in which initial coding begins with a relevant research finding or it may begin with

a selected theory. When conducting data analysis the researcher then digs deep into the raw data to allow the emergence of themes based on the previous findings or selected theory used. The third approach was summative approach qualitative content analysis which begins with the counting of words or manifest content then extends to the analysis to include some latent meanings and themes. This method resembles quantitative in the beginning but as analysis broadens, usage of words will be explored in an inductive manner hence the qualitative aspect of content analysis will start to remerge.

In qualitative content analysis, research analysis frequently takes place at the same time as data collection, many consider it as a mistake to continue accumulating data without examining it from time to time to see patterns or themes are starting to emerge (Woods, 2006). If there are, this will direct future gathering of data in a process known as 'progressive focusing', if this is not done the research risks to be swamped in data that increasingly becomes more difficult to analyse (Woods, 2006). In order for reliable and valid inference to happen qualitative content analysis then follows a systematic, organised and transparent procedure of processing data. For the purpose of this study conventional qualitative content analysis approach was selected and used because of the advantages it possesses such as data analysis was done by making direct inference to the data that was collected without imposing any previous any previous theories, themes and categories of data (Marying, 2000). Initial coding was done to the data, it lead to the emergence of new themes that yielded more codes and themes. Analysis of extensive codes resulted in further analysis to identify data related to research question, literature review and theoretical framework (Miles & Huberman 1994).

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Data was analysed by the researcher guided by six steps which started by defining the goals of research so that the research would be clear on what was to be achieved. The second stage involved the researcher's familiarisation with data that was being dealt with in this study which was interview transcripts. The researcher read and re-read them so that an immersed understanding of the collected data was achieved. Stage three involved the formulation of the themes that were emerging, from the coded data. The main themes were drawn from the contextual data and any other information that helped to better understand the data. A theme captures something significant about data in relation to the research question or some patterned responses or meaning within the data set. Frequently occurring themes were identified and the people who talked about the same theme identified so that further analysis and quantification was done to add rigour to the analysis (Woods, 2006). The fourth stage of the research involved the revision of the identified themes. Braun and Clarke (2006) talked about other proposed themes that may not be having enough data to support them or they may be too diverse. Some major themes may also be broken into smaller themes that are manageable themes. Themes should contain data that is coherent and there should also be clear distinction between themes. The fifth stage involved the formulation of sub themes, this refers to the process of selecting from an amorphous body of material bits and pieces that satisfy the researcher's curiosity and assist in augmenting the purpose of the study (Baptiste, 2001). These sub themes emerged as relationships and themes were identified.

Sub themes assisted to present a complete view of data which will then be used when interpreting and discussing the results of the findings. Themes and categories were revised during the process of data analysis and this gave rise to the final themes and subthemes augmented the findings from which conclusions were made. The last stage involved the connections of data that was interpreted through defining and redefining of themes which led to relationships being identified.

3.9 CONCLUSION

Descriptive survey design was used in the study where qualitative analysis was dominant. Two sets of questionnaires were utilised to collect data, that is one for Zimbabwean immigrants (Appendix- D) and one for medical personnel (Appendix-E). They both had open-ended and closed questions. Open-ended questions from questionnaires were qualitatively analysed and closed questions were statistically analysed. Semi structured interviews were used to collect data from Zimbabwean immigrants as a much more open approach to collect information from Zimbabwean immigrants as they verbally explained their experiences and perception without restrictions. Sample included adult Zimbabwean immigrants that had used the public health care facilities in Cape Town and the medical personnel that provide public health care to patients in Cape Town including Zimbabwean immigrants.

Permission to do the research was granted by the Senate Research Committee of University of The Western Cape following the approval of methodology and ethics involved (Appendix-C) and the Department of Health Western Cape (Appendixes-A&B). Consent was obtained from the participants and their rights were explained to them either verbally when conducting interviews or in written form in terms of questionnaires. This chapter explained the research methodology which included sampling, data collection instruments, ethical standards, that were maintained. Data presentation, findings and discussions will be presented in the next chapter which is chapter four.

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CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the research findings. The presentation of the findings endeavoured to answer the research question. The questionnaires designs were guided by literature review and research question. Two sets of questionnaires were used that is one for Zimbabwean immigrant patients that used public health care facilities and the other one for Medical personnel. All the thirty questionnaires for Zimbabwean immigrant patients were completed as the researcher asked the respondents to complete while he was in the vicinity of the medical facilities waiting to collect the questionnaires as they were completed. Subsequently all the thirty questionnaires sent to the four public healthcare facilities were completed and returned. Questionnaires gathered basically quantitative data and an excel package was used to analyse and summarise the data. Qualitative content analysis was used to analyse the open ended questions from the questionnaires as well as responses from semi- structured interviews.

The questionnaires and semi-structured interview data gave an insight of the experiences of Zimbabwean immigrant patients as they used public healthcare facilities in Cape Town. Triangulation of questionnaires and semi-structured interviews illuminated the experiences of Zimbabwean immigrant patients through convergence of similar findings from these two sources.

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4.2 SUMMARY AND ANALYSIS OF RESPONSES OF ZIMBABWEAN IMMIGRANTS.

The questionnaire for Zimbabwean immigrants had mainly three sections as described in chapter three. Section A contained biographical questions, Section B contained the experiences of Zimbabwean immigrants as they used public health care facilities in Cape Town, this section answers the research question, and Section C which discusses the attitudes of medical personnel towards immigrant patients, knowledge of policy on immigrants access to public health care and general question which complement the answering of research question.

4.2.1 BIOGRAPHICAL INFORMATION OF ZIMBAWEAN IMMIGRANTS.

Table 1 below shows the biographical information of the Zimbabwean immigrants that participated in the questionnaire segment of the study. It shows the gender of the Zimbabwean immigrants, ages, different marital statuses of the Zimbabwean immigrants, educational attainments, the years that they arrived in Cape Town, the reasons for coming to South Africa, their immigration statuses in South Africa as well as their sources of income in Cape Town. The different biographical variables shown in table 1 also influenced the experiences of the Zimbabwean immigrants in accessing public health care at different health facilities in Cape Town.

TABLE 1: ZIMBABWEAN IMMIGRANTS BIOGRAPHICAL INFORMATION

BIOGRAPHIC VARIABLES	SAMPLE TOTAL (n=30)	% IN SAMPLE
GENDER		
Male	19	64%
Female	11	36%
TOTAL	30	100%
AGE		
18-25	9	30%
26-33	15	50%
34-41	4	13%
42-49	2	7%
TOTAL	30	100%
MARITAL STATUS		
Never married	7	23%
Married	18	60%
Separated	5	17%
Widowed	0	0%
TOTAL	30	100%
EDUCATIONAL ATTAINMENT		
Ordinary level	15	50%
Advanced level	5	17%
Diploma	7	23%
First Degree	3	10%
TOTAL	30	100%
YEAR OF ARRIVAL		
2001	1	3%
2004	2	7%
2005	2	7%
2006	4	13%
2007	7	23%
2008	10	34%
2009	4	13%
TOTAL	30	100%
RESAONS FOR EMMIGRATION		
Better employment opportunities	21	70%
Better educational opportunities	5	17%
Political stability	4	13%
TOTAL	30	100%
IMMIGRATION STATUS		
Permanent resident	2	7%
Temporary resident	2	7%
Student	1	3%

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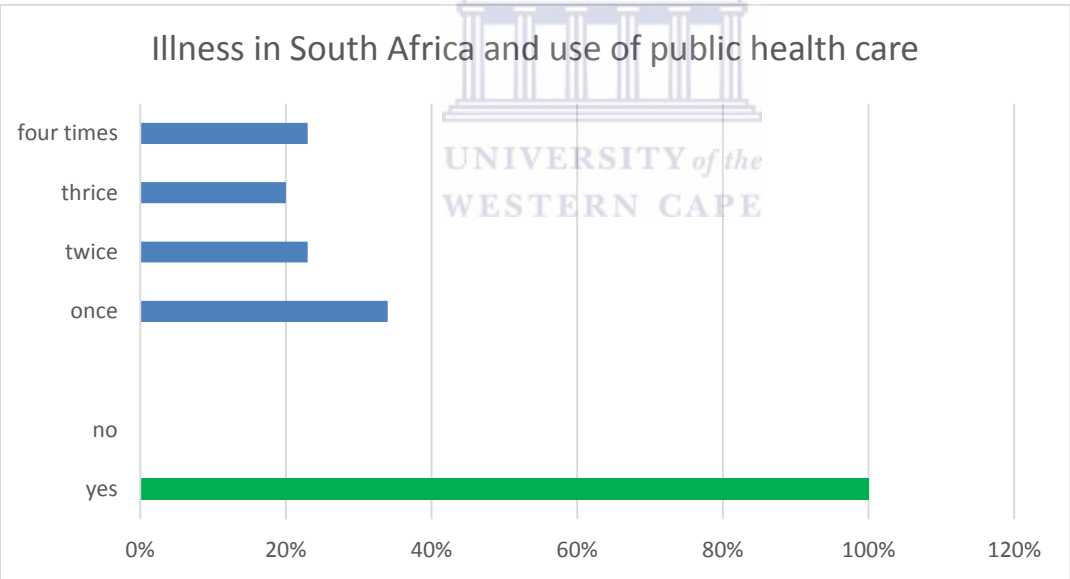
Refugee		8	27%
Asylum seeker		16	53%
No documentation		1	3%
	TOTAL	30	100%
SOURCE OF INCOME IN SA			
Working		22	74%
Trading		4	13%
Dependent on others		4	13%
	TOTAL	30	100%

4.2.2 EXPERIENCES OF ZIMBABWEAN IMMIGRANTS AT PUBLIC HEALTH CARE FACILITIES IN CAPE TOWN.

4.2.2.1 ILLNESS IN SOUTH AFRICA AND USE OF PUBLIC HEALTH CARE FACILITIES.

FIGURE 1: Illness in South Africa and use of public health facilities



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In figure 1 two variables of immigrants experiences are shown. The first variable is that of immigrants' illness in South Africa and the second variable is the number of times they used public health facilities. All the immigrants indicated that they had fallen sick in South Africa during their stay in Cape Town that they have used the public health care facilities as indicated by the green bar. Blue bars indicated the number of times that immigrants used public health care facilities. More immigrants did use the public health care facilities in Cape Town more than once. The immigrants could have been susceptible to sickness because of change of the environments that they were used to in their home countries and the conditions that they encountered in Cape Town, which included poor sanitation. Ama & Oucho

(2008) are of the same idea that separation of immigrants and refugees from their home countries, relatives, members of their families 'possessions, and traditional routines of behaving in their home countries makes them susceptible to sickness. Biswas et al (2011) picked out that in Denmark undocumented migrants and other new arrivals often experience precarious living conditions that may have negative health consequences which may result in poor mental health due to social isolation, poverty loss of status and hostility from local population. Migrants are also often exposed to poor living conditions and more likely to be doing jobs that are strenuous and lack basic occupational safeguards and workers' rights (IPPR, 2006).

4.2.2.2 IMMIGRANTS IDENTIFICATION/PROOF OF RESIDENCE AND ACCESS TO PUBLIC HEALTH CARE FACILITIES.

FIGURE 2: Identification

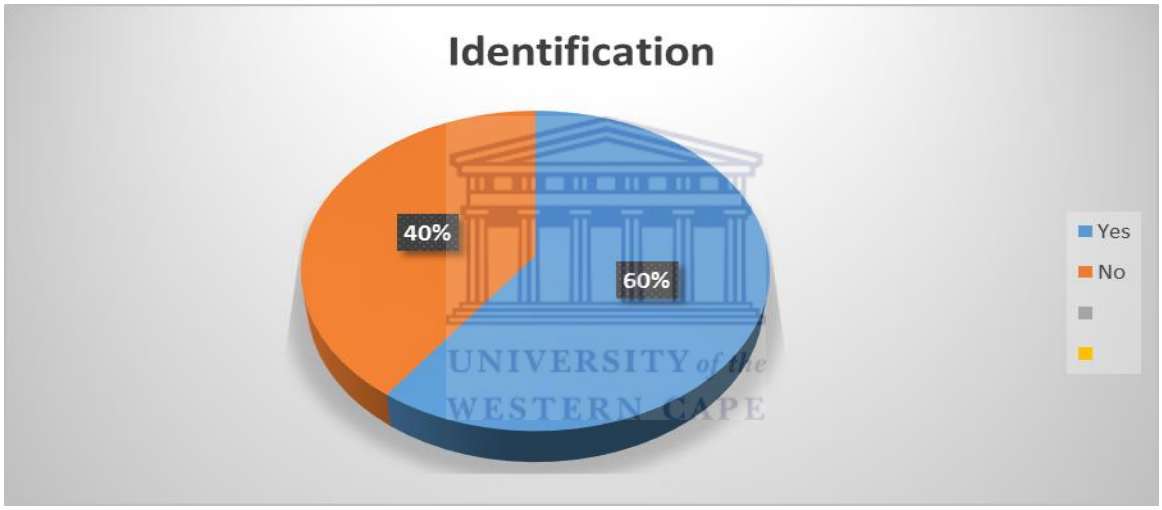

FIGURE 3: Proof of residence

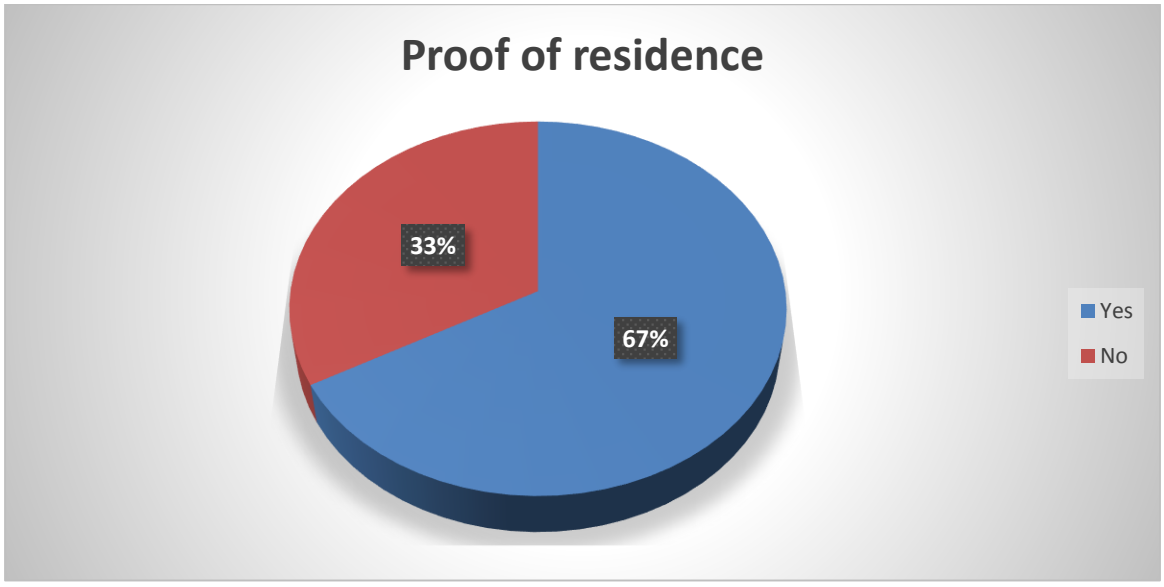

Figure2 and figure 3 respectively show the experiences of Zimbabweans when they were asked to produce their identification documents and proof of residence so that they could be assisted. Both figures 2 and 3 shows that more than half of the immigrants were asked to either produce some form of identification and or to produce proof of residential address. Failure to produce acceptable identification and proof of residence in most cases meant the immigrant was denied access to public health care. South African law and policy on health care affords immigrants, right to access public health care, even if they fail to produce the identification or proof of residence. When refugees and asylum seekers visit community health care facilities, they should produce their refugee status or asylum seeking papers, but having those papers in reality means nothing, staff at the registration points do not recognize the legitimacy of these identification documents because they have not been properly trained (Robinson 2005). Despite those legal provisions few departments or public service providers have adequate practices relating to the inclusion of refugees, asylum seekers and migrants (CORMSA 2008). Shindondola et al (2001) made similar observations when they said in practice non-citizens, both with and without status are still marginalized in the provision of social security and the relevant minimum core benefits as provided in the law. Despite free emergency care and basic health care including antiretroviral therapy being available by law, documented and undocumented immigrants face challenges in accessing it (Harper & Raman 2008). Cross-border migrants face challenges in accessing public health care services despite the presents of protective legislation, identity documents cannot prevent discrimination or ensure social inclusion. In United States the fact that one in an immigrant with or without documentation makes it difficult for immigrants to access health care, Park (2011) noted that undocumented migrants are put at a serious disadvantage in accessing health care services due to their legal status or just being an immigrant, even for those with documentation.

4.2.2.3 CASH PAYMENT AT A PUBLIC HEALTH CARE FACILITY.

Figure 4 shows the responses for question fourteen which asked the immigrants whether they were asked to make a payment at the public health care facility that they used. Twenty three percent of the immigrants agreed that they were asked for cash payment upfront and seventy seven said they were not asked. In South Africa free health care refers to health services that are rendered free at the point of contact at public sector clinics, community health centers and hospitals. The policy implemented in 1994 remains in force and free health care services includes, pregnant women and those formally unemployed. South Africans who are formally unemployed register with Department of labour and they are issued with proof of unemployment registration that immigrants cannot access .This leaves immigrants who are unemployed in a precarious position as the front staff at the public health care facilities use that against them to make payments. Free health care is a policy issue and it is the frontline medical staff that decides whether one qualifies for free health or not, but considering how staff at public health care facilities and any other places deal with immigrant population, it is difficult for immigrants to benefit from such a facility. Despite free emergency care and basic health care including

antiretroviral therapy being available by law, documented and undocumented immigrants face challenges in accessing the services (Harper & Raman, 2008).

FIGURE 4: Cash payment

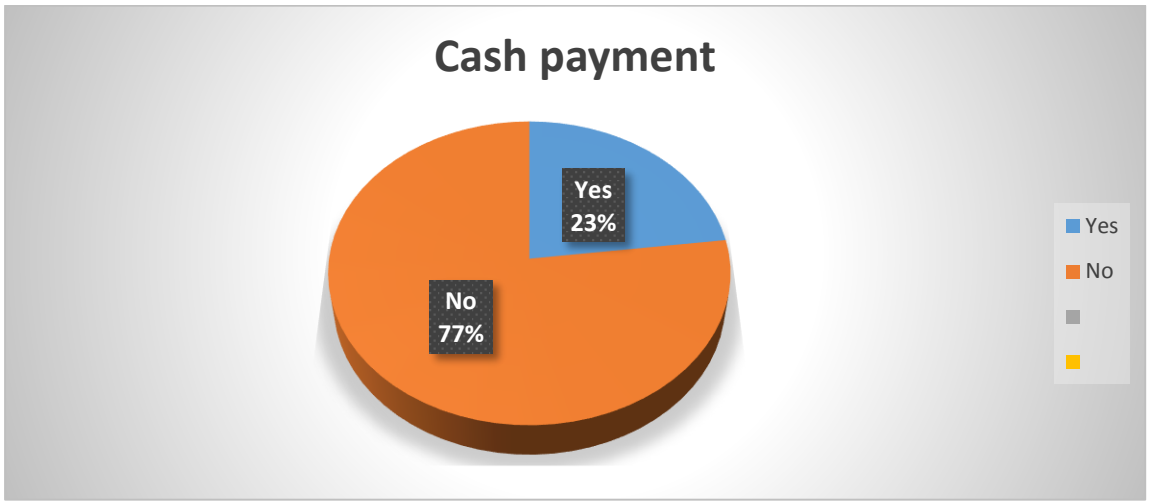

FIGURE 5: How much was paid/ability to pay

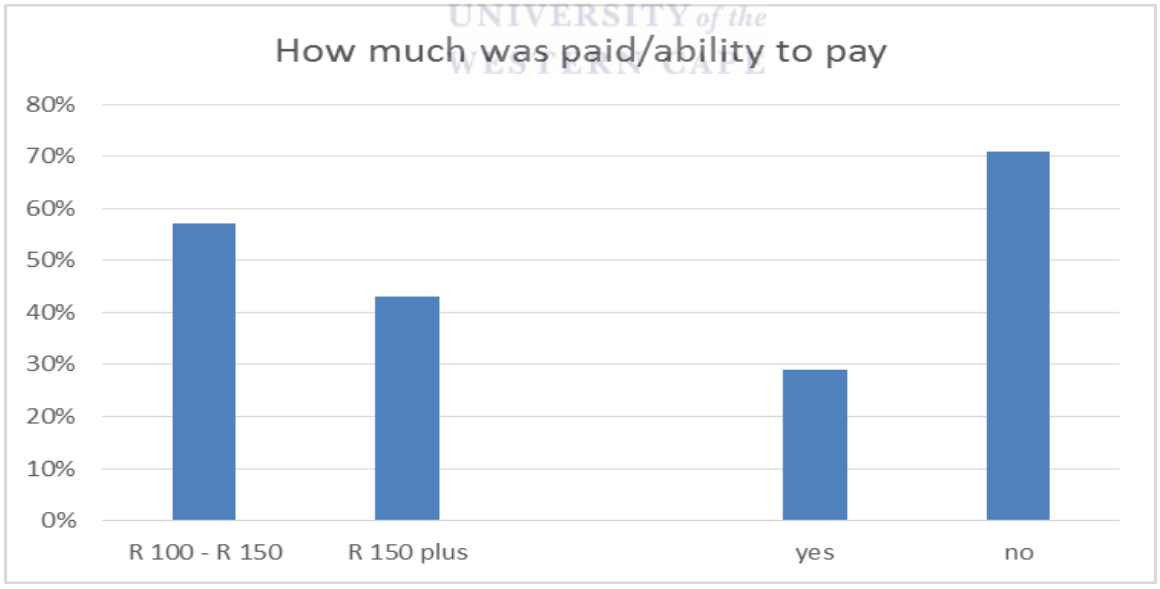

Figure 5 shows two variable that is the amount of money that the Zimbabwean immigrants were asked to pay. The other variables in that Figure 5 shows those Zimbabwean immigrants that were asked to make the cash payment, seventy one percent of them were not able to make only twenty nine percent manage to make the payment. For those that managed to make the payment fifty seven percent of them paid between the range R100 – R150 and forty three percent paid R150 or more . Economic conditions

of immigrants make it impossible in many instances to be able to make payments required at public health care facilities more so if the immigrant patient is frequently sick that they need to go to public health care facilities a couple of times. Economic conditions for many immigrants is so bad, for those who work, they work mostly in menial jobs which do not pay much because of lack of legal documentation which allows them to work, such that they end up taking up jobs that that do not pay well because employers take advantage of their immigration status. These findings are supported by Hermer (2008) who states that in United States of America access of immigrants to health care is heterogeneous in all the states, but there is a general trend that many immigrants have lower incomes and are less able to pay for care out of pocket.

4.2.2.4 WHAT TRANSPIRED AFTER FAILURE TO MAKE PAYMENT?

TABLE 2: What transpired after failure to make the payment?

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
Payment for medical service	Affordability	• I had no money with me so went home to look for money. (qnr1) • I truly had no money to make a payment so I went home. (qnr4) • I am not working, so I could not make the payment. (qnr9)
	Medical Personnel attitudes	• Nurse told me to go home because I had no money.(qnr17) • Was told to go and work and raise the money.(qnr22)

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Table 2 shows the themes and sub-themes of question seventeen of what transpired after the immigrants' failure to make that required payments at the public health care facilities. All the immigrants who could not make the payments were not assisted and they had to leave the facility. Literature has it that economic conditions act as barriers in accessing public health care to immigrants as Hermer (2008) puts

it across that in United States access of immigrants to health care is heterogeneous in all the states, but there is a general trend that many immigrants have lower incomes and are less able to pay for care out of pocket.

4.2.2.5 EXPERIENCES OF ZIMBABWEAN IMMIGRANTS IN THEIR LAST VISIT AT A PUBLIC HEALTH CARE FACILITY IN CAPE TOWN.

TABLE 3: Experiences of Zimbabwean immigrants in their last visit at public health facility

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
Experiences of immigrants at public health care facilities	Negative attitude of staff	• Was told to go to another clinic that served my area.(qnr2) • Nurses were too slow in serving patients.(qnr3) • Was sent home because my asylum seeker permit was expired.(qnr6) • Lady at registry spoke IsiXhosa only to us all.(qnr12) • Did not want to accept my passport because it hand no permit.(qnr 17) • Was told to go home and bring proof of residence.(qnr27) • Staff was very rude to me and others.(qnr28)
	Positive attitude of staff	• Nurse was very friendly and helpful.(qnr8) • Nurse took her time to assist me.(qnr15)
	Overcrowded	• Entire service was too slow.(qnr18)

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		• There was too much noise in the gallery.(qnr25) • We were at clinic at 5am but we were only assisted at 14:00.(qnr 26)
	Xenophobia	• They served citizens first then non-citizens last.(qnr29) • Nurse mocked by asking whether they come to SA make babies.(qnr 30) • Nurse said you should go back to your countries and deliver there.(qnr19)

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After the questions that asked possible barriers to health care, question eighteen asked the immigrants to mention their experiences in their last visit at a public health care facility, ninety three percent of the immigrants reported experiences that were negative such as the bad attitudes of medical personnel, the facilities being over crowded, hence service was at a snail pace and xenophobic attitudes of medical staff towards the immigrant patients. On the other hand seven percent of the Zimbabwean immigrants reported awesome experiences in their visits as they said the medical staff was friendly and took their and effort to assist patients.

4.2.3 POLICY, ATTITUDE AND GENERAL INFORMATION ON ACCESS TO PUBLIC HEALTH CARE.

Questions 19, 20, 21, 22 and 23 are all linked as they refer to the knowledge and application of South African policy on public health care for immigrant population.

FIGURE 6: Knowledge of South Africa's policy on immigrants' access to public health care

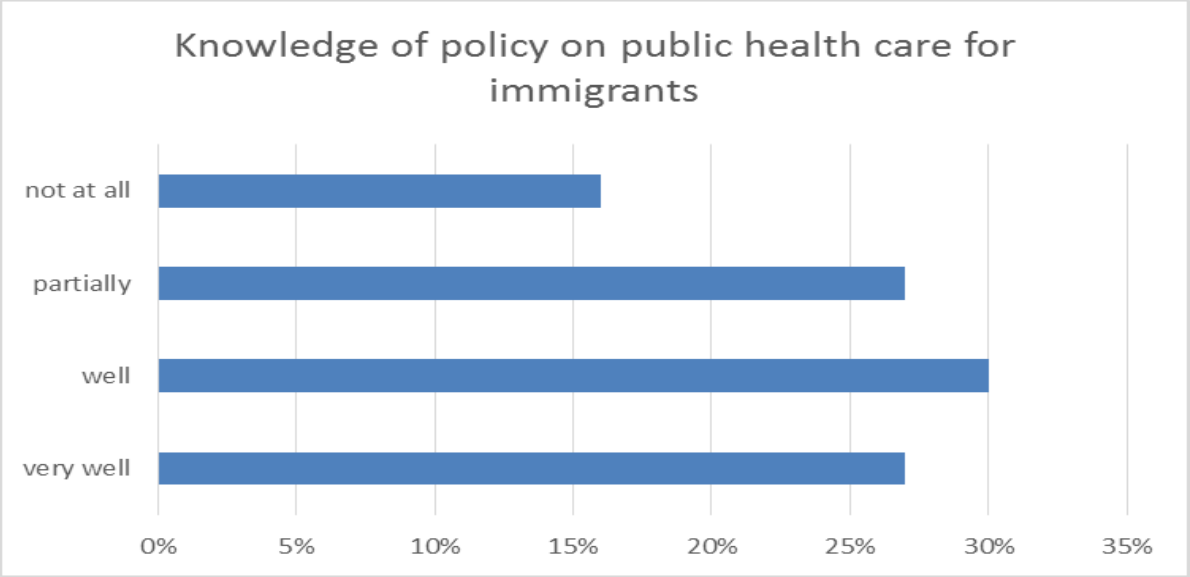

Figure 6, shows the responses of the Zimbabwean immigrants to question nineteen. Eighty-four percent of the Zimbabwean immigrants were partially aware to fully aware of what the policy says and sixteen percent of the Zimbabwean immigrants were not aware of the policy stipulations. Lack of knowledge on what policies and the law say about immigrants could have also aggravated the barriers that the immigrants face at public health care facilities because they could not stand for themselves or challenge some of the decisions as lack of familiarities with the host nation health care system could have resulted in the immigrant population developing limited trust in the whole system as they were not aware of how the system could assist them to access health care (Lamb & Smith, 2007).

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FIGURE 7: Is policy for immigrants' access to public health care well implemented

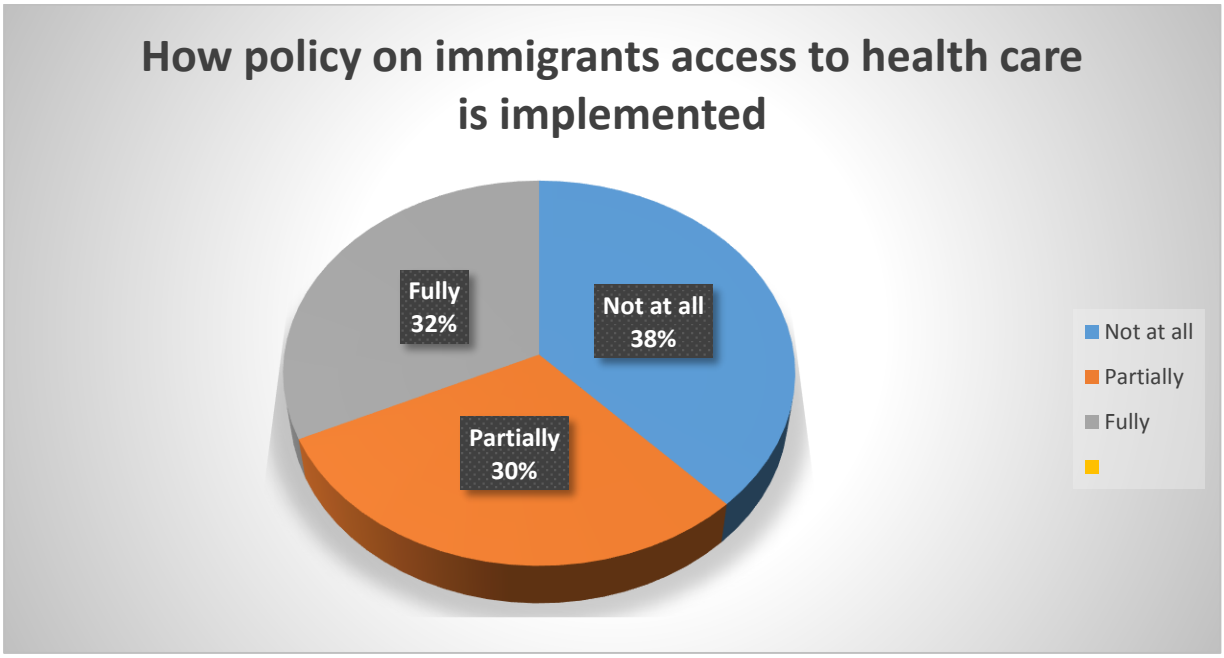

Figure 7, referring to question twenty shows the responses of Zimbabwean immigrants that responded saying they were partially aware to fully aware, sixty eight percent indicate that it was not implemented at all to partially implement and thirty two percent said it was implemented well to very well.

FIGURE 8: Immigrants' perception of knowledge on public health care policy for medical staff

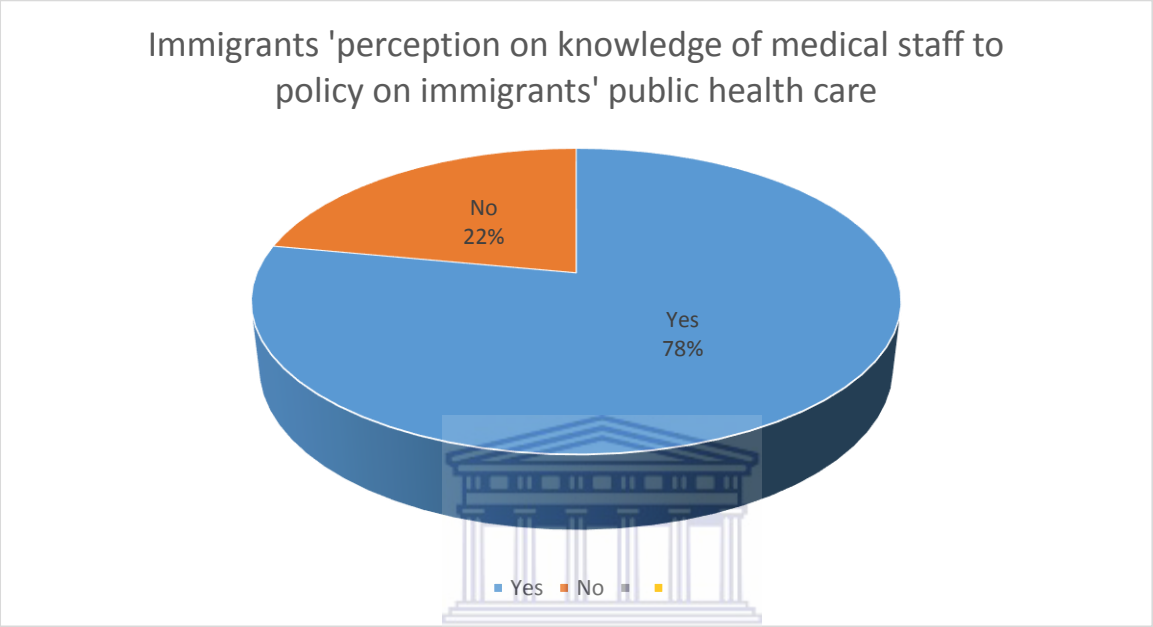

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Figure 8, refers to question twenty one, and the responses are from those Zimbabwean immigrants who said they were partially aware to fully aware of the policy on health care for immigrant. Seven eight percent responded by saying no and only twenty two percent said yes.

4.2.3.1 REASONS WHY FRONTLINE STAFF IS UNAWARE OF POLICY ON PUBLIC HEALTH CARE FOR IMMIGRANTS.

TABLE 4: Reasons why frontline staff is unaware of policy on public health care for immigrants

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
Lack of knowledge of policy on public	Professional attributes	▪ Send people away without proof of residence (qnr1). ▪ Refuse to accept legal documents as identification (qnr4).

health for immigrants by frontline staff.		▪ Need payment from people who do not work (qnr11).
	Personal attributes	✓ Harass immigrant patients. (qnr9) ✓ Do not treat people with dignity. (qnr22) ✓ Deprive immigrants' access to public health facilities. (qnr18) ✓ They are arrogant. (qnr30) ✓ They are very rude to patients. (qnr6) ✓ They are terrible. (qnr10) ✓ They have bad attitudes. (qnr12)
	Xenophobic tendencies	• Use languages that immigrants do not understand. (qnr16) • Treat locals better than immigrant people. (qnr2) • Refer to immigrants with derogatory names. (qnr3)
	Work load	▪ They are overworked which makes them arrogant. (qnr15)

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Table 4, refers to question twenty two which is an open-ended question. It is well linked with question twenty one which asks the Zimbabwean immigrants whether frontline staff at public health facilities were aware of the public health policy for immigrants. Question twenty two asked for the reasons why immigrants who said no arrived at that decision. They are many reasons why the Zimbabwean immigrants arrived at that decision. In South African there is an assumption that most public policies lack proper implementation as a result of the individuals who are supposed to drive them but are reluctant or not properly informed about them, despite those legal provisions few departments or public service providers have adequate practices relating to the inclusion of refugees, asylum seekers and migrants (CORMSA, 2008). Literature shows that policies are not being practiced, Landau et al (2005)

argue that although attitudes towards non- nationals especially black foreigners vary across South Africa's socio economic and ethnic spectrum, there is strong evidence that non-nationals living and or working in South Africa face discrimination. Policies are not implemented fully regardless of their existence and this has a direct bearing to the immigrant population in South Africa which is affected when accessing basic services which by law they are allowed to enjoy. Rispel et al, (2009) highlights a major weakness of most policies which is lack of monitoring and evaluation systems, with clear indicators that incorporate system responsiveness. Health inequalities must be measured, social policies must be carefully designed and effectively implemented, addressing the constraints identified, monitoring and evaluation systems need improvement and participation of communities needs to be encouraged through conducive and enabling environments (Rispel et al, 2009). When refugees and asylum seekers visit community health care centers and public hospitals, they should produce their refugee status or asylum seeking papers, but having those papers in reality means nothing, staff at the registration points do not recognize the legitimacy of these identification documents because they have not been properly trained (Robinson, 2005). Policies that spell out how migrant populations should be treated are there, but what is lacking is mostly is the practice.

FIGURE 9: Immigrants who said yes to proper implementation of public health care

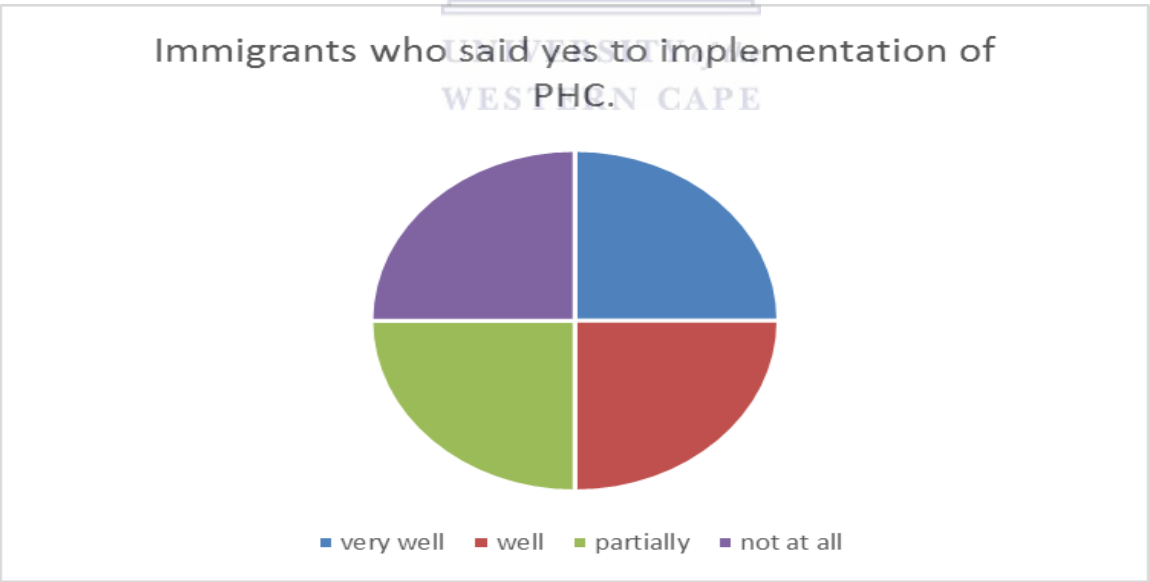

Figure nine refers to question twenty three, for those immigrants who said that frontline staff at public health facilities were aware of policy on public health care for immigrant twenty five percent of them responded saying that the policy was not implemented at all, twenty five percent said it was partially implemented, twenty five percent said it was well implemented and twenty five percent said it was very well implemented.

FIGURE 10: Attitudes of frontline staff/medical staff

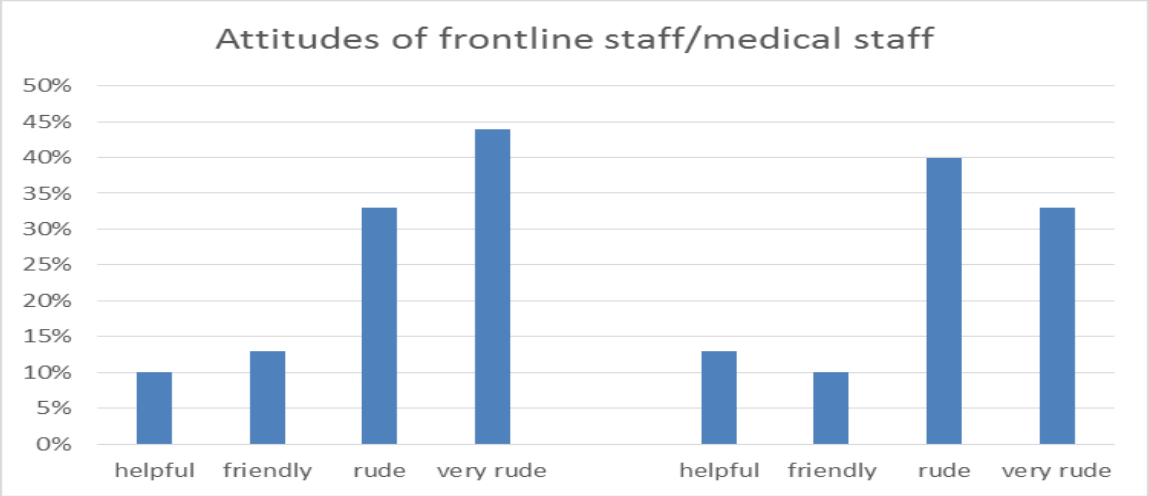

Figure 10 refers to questions twenty four and twenty five. Immigrants were asked about the attitudes of the frontline staff and nurses/doctors that served them in their last encounter at a public health facility. On frontline staff seventy seven percent said that they were rude to very rude and only twenty three percent said they were friendly and helpful. On the medical staff the immigrants said seventy seven percent were rude to very rude and twenty three percent said they were friendly to helpful. The attitude of providers of public health care can act as barrier to access to health care. Lamb & Smith (2007) mentioned that hospitalization and other healthcare interaction that is not conducted in a sensitive manor… may re-traumatize those under care they further explain that racism and discrimination have been shown to reduce the access to healthcare in some marginalized groups and is likely to affect refugee groups as well. Jeff Radebe Minister in the Presidency visited day clinics on a fact finding mission and did get serious complains from patients who said the medical personnel had bad attitudes towards patients which is poor work ethics (Dano, 2015).

FIGURE 11: Communication Problems

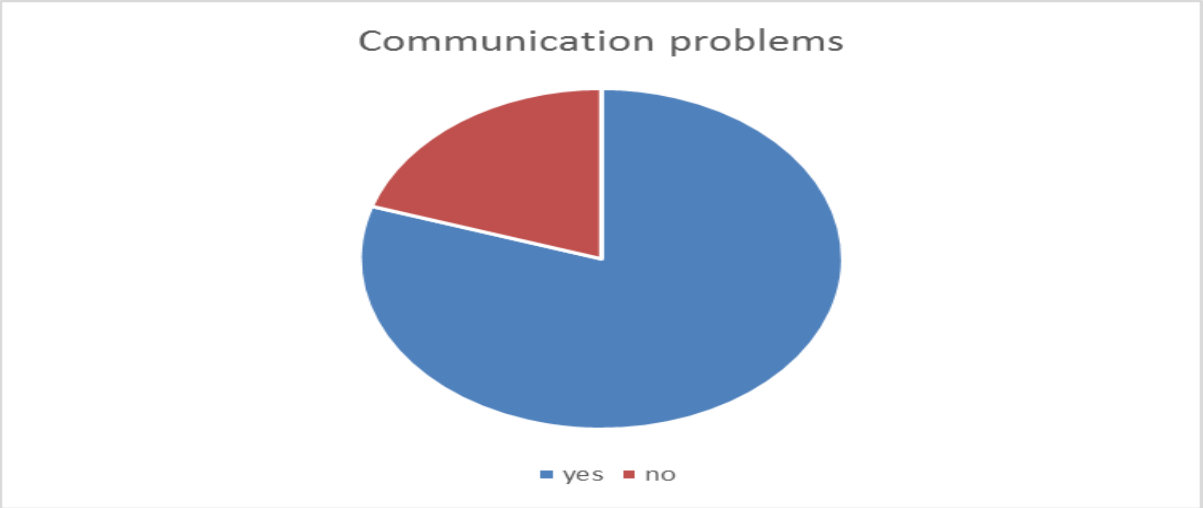

Figure 11, refers to question twenty seven. The Zimbabwe immigrants' responses show that eighty percent of them had experienced communication problems and only twenty percent did not experience communication problem. Communication problems are serious barriers to access to health care. Communication can be a major barrier for immigrant patients to access public health care (Robinson, 2005). Robinson (2005) describes a situation where immigrant patients spent more than eight hours at some public health care facilities because of their mother tongue not being understood by those who are supposed to help them in the medical fraternity. Furthermore immigrant patients may face discrimination from health service providers who may also not speak their languages or understand their health history (IOM, 2010). Lamb & Smith (2007) argue that it is not only the absents of interpreter services that creates a barrier to the provision of public health care service to immigrant populations but the effective use of it as well. They gave an example of the Dinka people from South Sudan who are a minority in Australia who have been victims of non-use of interpreter services. They said while a free telephone interpreter service exists for medical practitioners many doctors are reluctant to use it. This non-use of interpreter service may create barriers of access to public health care to immigrants' patients who may need it as a last resort so that they may be afforded effective public health care services.

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4.2.3.2 HOW COMMUNICATION PROBLEMS WERE RESOLVED.

TABLE 5: How communication problems were resolved.

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
COMMUNICATION PROBLEM	FACILITY'S SOLUTIONS	• Use of common language such as English. (qnr 11) • Use of interpreter. (qnr14) • Use of escorts that would have accompanied patients. (qnr6) • Use of other members of the medical staff. (qnr 27)

	PATIENT'S SOLUTIONS	• Use of another patient who understands their language. (qnr22) • Use of escorts that would have accompanied patients. (qnr3)

FIGURE 12: Xenophobic name calling

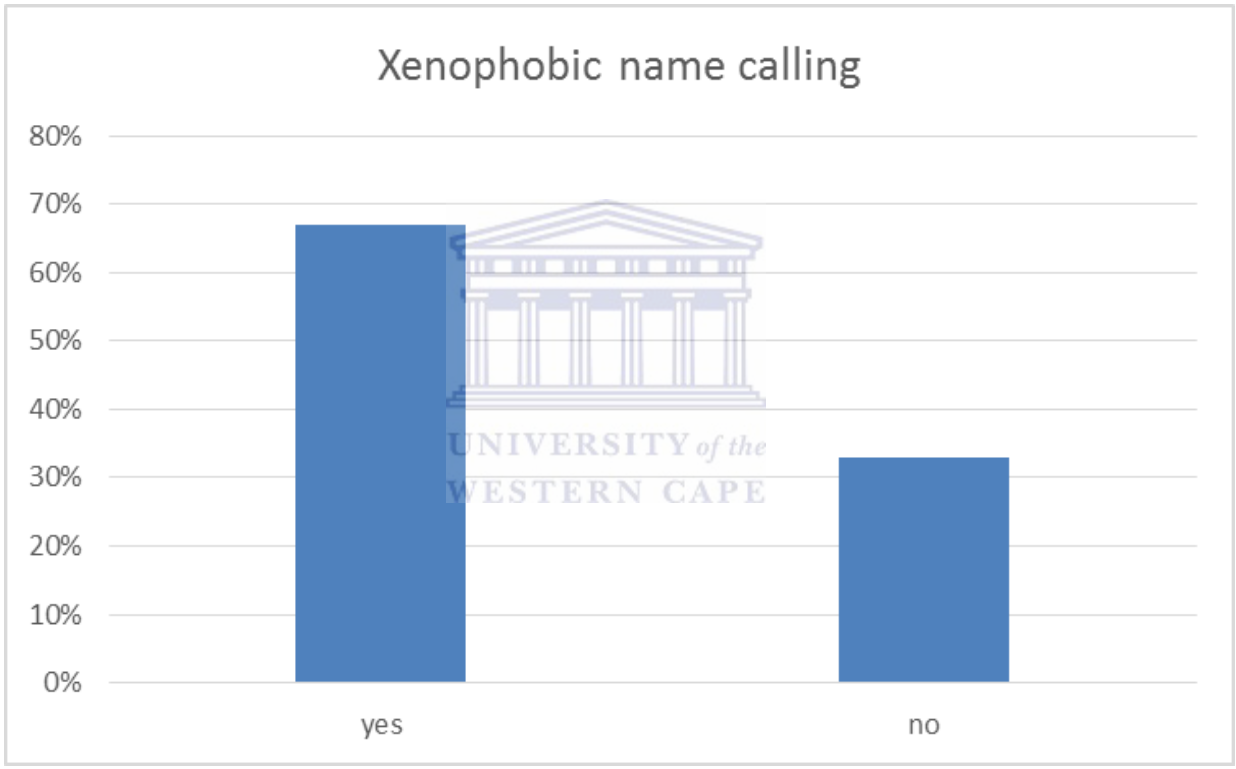

Figure 12, refers to question twenty nine .Sixty seven percent of the Zimbabwean immigrants indicated that they had been called with a xenophobic name and thirty three percent said no. Medical personnel at times do refer to immigrant patients with derogatory names this affects the immigrants and can contribute to their barriers in accessing public health care. Crush & Tawodzera (2011) discussed experiences of some immigrants who were called names or insulted by nurses who asked immigrant women why they came to have babies here in South Africa and should go back to their home countries and make babies there.

TABLE 6: Xenophobic name calling

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
Xenophobic name calling	By medical personnel	▪ Was called kwerekwere. (qnr7) ▪ Was called those from across borders. (qnr11)
	By other citizen patients	▪ Other local patients called me foreigner. (qnr18)

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4.2.3.3 ARE SOUTH AFRICANS ACCOMODATIVE TO IMMIGRANTS?

FIGURE 13: Are South Africans accommodative to immigrants?

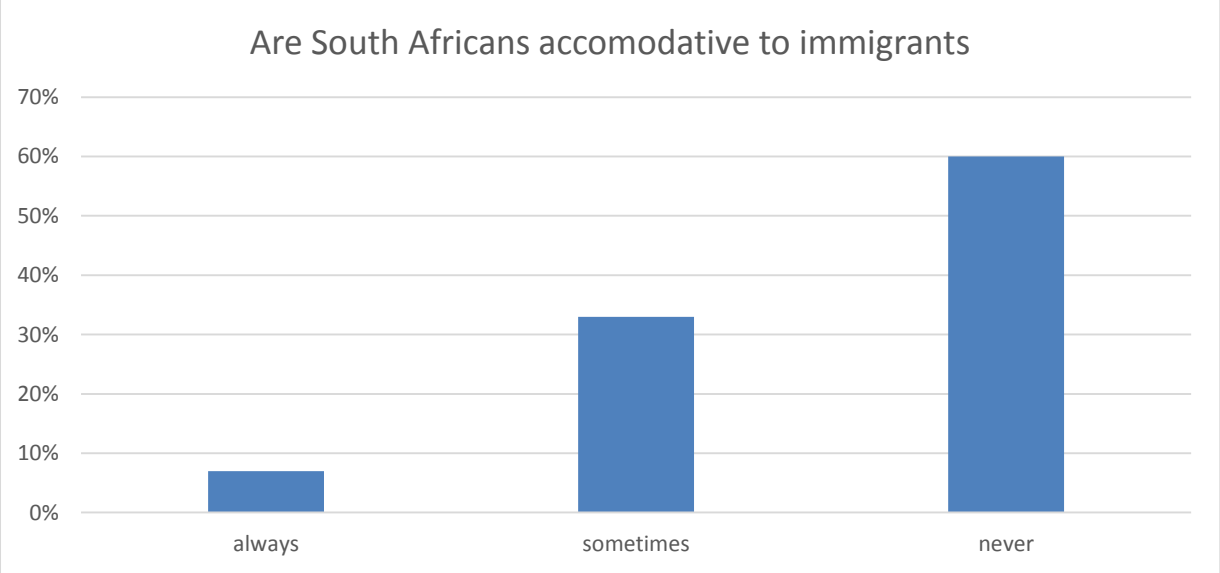

Figure 13, refers to question thirty five, and ninety three percent of the immigrants said South Africans are never accommodative to sometime accommodative, only seven percent said yes they are accommodative. The Zimbabwean immigrants could have arrived on such a decision because of their

experiences with South Africans. Literature supports the notion of South Africans being less accommodative to immigrants. Cross border migrants continue to be portrayed as 'disease carriers' and viewed as placing an unnecessary burden on all social services in general and public health care systems in particular (Worth, 2006). This is not peculiar to South Africa only it also happens in United States where stereotypes of immigrants coming to United States are seen to be using up social services and taking services away from tax payers there by creating a discriminatory stigma (Moss, 1996).

4.2.3.4 PROBLEMS CREATED WHEN ONE IS DENIED ACCESS TO PUBLIC HEALTH CARE.

TABLE 7: problems created when one is denied access to health care

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
Problems created as a result of denial of access to public health care.	PERSONAL	▪ One does not get better. (qnr 5) ▪ Continue to endure suffering. (qnr8) ▪ Can succumb due to illness. (qnr11) ▪ An individual continues to endure deterioration as a result of lack of treatment. (qnr 24).
	ECONOMIC	▪ Loss of income due to absenteeism from formal paid employment. (qnr12) ▪ Loss of the job. (qnr14) ▪ Loss of customers if one does self-job as they will be lack of consistence in the business. (qnr17) ▪ Loss of income as the person who will be sick will not be able to trade to earn a living as they need to recuperate at home

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		because sickness inhibits them from being able to work for themselves. (qnr 7)
	SOCIAL	▪ Family will suffer if person is breadwinner. (qnr 20) ▪ May spread disease to others. (qnr 23) ▪ May suffer isolation from others. (qnr3) ▪ Family may also suffer isolation from other members of society as they fear to contracting the disease. (qnr 6)

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FIGURE 14: Problems associated with denial of public health care which leads to use of alternatives to public health care.

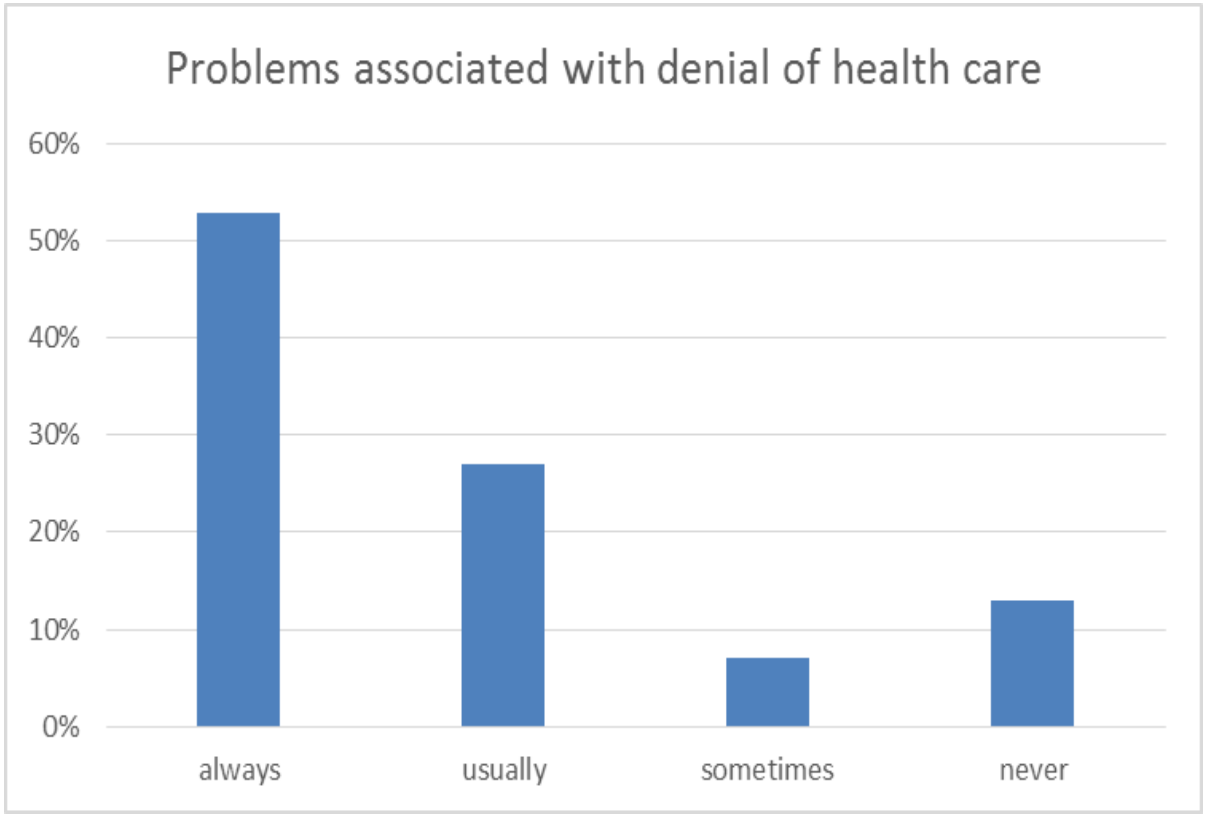

Figure 14, refers to question thirty four. Eighty seven percent of immigrants indicated that they use alternatives to public health care sometimes, usually and always. Thirteen percent said they have never used alternative to public health care. Immigrants could use alternative health care to complement public health care, but in most cases they used alternative health care because they will have been denied access to public health care. Perez-Escamilla, Garcia & Song (2011) outlined similar observation of immigrants who used alternative healthcare from the main stream healthcare when they explained how Mexican farm workers who live in the California counties in the United States and Mexican border areas preferred to cross the border and use Mexican primary care other than United States primary health because patients perceptions of healthcare quality were higher in patients who use Mexican primary health care than those that used United States primary healthcare.

4.3 SUMMARY AND ANALYSIS OF RESPONSES TO MEDICAL PERSONNEL

The questionnaire for the medical personnel as said in chapter three had questions one to ten that asked biographical question such as age, gender, ethnicity, appointment of the medical personnel, experience they had on the job they are doing, languages they speak and places of residents. Questions eleven to eighteen, aimed at determining the medical personnel encounters with immigrant patients such as whether they had at any time sent an immigrant patient way without attending to them, how do they assist immigrant persons who cannot speak English or any other South African language and whether they offered preferential treatment to patients that are citizens over immigrant patients. Questions nineteen to twenty five were about the medical personnel's knowledge about health policy towards immigrant as well their perception on government's intervention to assist immigrants and its ability to provide resources needed for the public health care sector.

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4.3.1 BIOGRAPHICAL INFORMATION OF MEDICAL PERSONNEL.

Table 8 below show the biographical information of the medical personnel that participated in the study. It shows the gender of the medical personnel, ages, ethnicity, different marital statuses of the medical personnel, educational attainments, places where they resided in Cape Town, professional qualification, the number of years doing that job, their first language , number of languages they can speak. The different biographical variables shown in table 8 also influenced their encounters with Zimbabwean immigrants as they accessed public health care at different health facilities in Cape Town.

TABLE 8: Biographical information of medical personnel

BIOGRAPHIC VARIABLE	SAMPLE TOTAL (n=30) n	% IN SAMPLE
GENDER		
Male	4	13%
Females	26	87%
TOTAL	30	100%
AGE		
20 - 25 years	2	7%
26 - 30 years	6	20%
31 - 35 years	7	23%
36- 40 years	4	13%
41 - 45 years	5	17%
46 - 50 years	5	17%
51 - 55 years	1	3%
TOTAL	30	100%
MARITAL STATUS		
never married	15	50%
Married	11	37%
Widowed	1	3%
Divorced	3	10%
TOTAL	30	100%
EDUCATIONAL ATTAINMENT		
First Degree	5	17%
Diploma	11	37%
Matric	6	20%
Grade 11	5	15%
Grade 08	3	10%
Standard 10	0	0%
TOTAL	30	100%
PROFESSIONAL QUALIFICATION		
Professional Nurse	19	68%
Admin Clerk	5	19%
Chief radiographer	1	3%
Enrolled nurse	1	3%
Senior staff nurse	1	3%
Senior staff admin clerk	1	3%
TOTAL	30	100%
WHERE DO YOU RESIDE		
High Density	12	40%
Medium Density	17	57%
Low Density	1	3%

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TOTAL	30	100%
NUMBER OF YEARS ON THE JOB		
0-5 years	13	44%
6-10 years	3	10%
11-15 years	4	13%
16-20 years	4	13%
21-25 years	4	13%
26 - 30 years	1	4%
31 - 35 years	1	4%
TOTAL	30	100%
WHAT IS YOUR FIRST LANGUAGE		
Xhosa	13	44%
Afrikaans	13	44%
English	4	12%
TOTAL	30	100%
HOW MANY LANGUAGES DO YOU SPEAK		
Two	17	56%
three	10	34%
Four	3	10%
TOTAL	30	100%

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4.3.2 MEDICAL PERSONNEL ENCOUNTERS WITH ZIMBAWEAN IMMIRGANTS.

4.3.2.1 ABILITY TO SPEAK ANY LANGUAGE OTHER THAN SOUTH AFRICAN OFFICAL LANGUAGES.

FIGURE 15: Knowledge of foreign languages

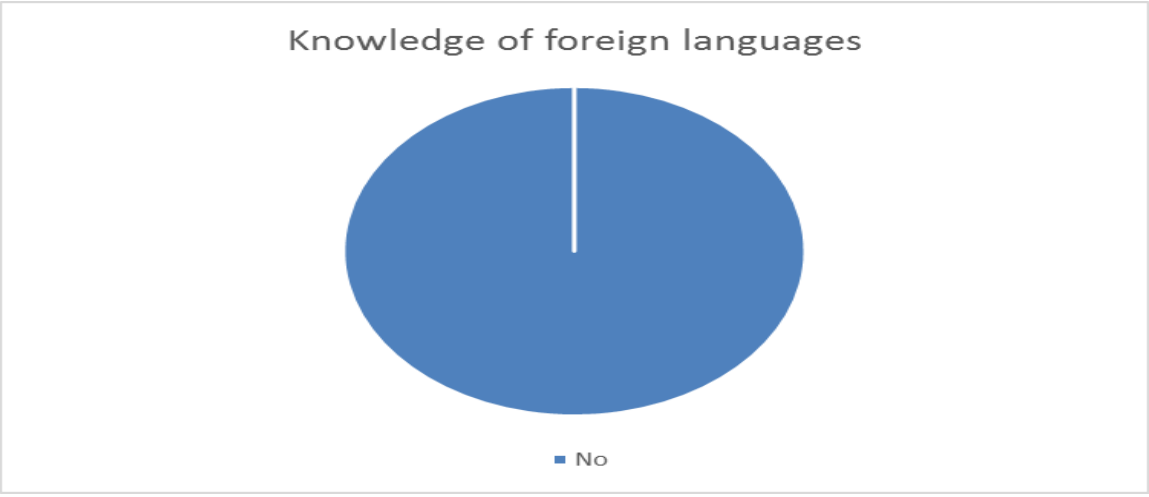

Figure 16, which refers to question eleven shows that all the medical personnel that participated in the study could not speak any other language that is not one of South African official languages. In the table eight which contains their biographical information one can see that all the medical personnel

spoke more than one language but none could speak a language which was not among the South African official languages. The inability for medical personnel to speak languages of their patients, contributes to barriers in access to health care for the patients, Robinson (2005) describes a situation where immigrant patients spent more than eight hours at some public health care facilities because of their mother tongue not being understood by those who are supposed to help them in the medical fraternity.

4.3.2.2 COMMUNICATION WITH IMMIGRANTS WHO SPOKE LANGUAGES THAT MEDICAL PERSONNEL DID NOT UNDERSTAND.

TABLE 9: Communication with immigrants that cannot speak South African local languages

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
COMMUNICATION	THOSE WHO SPEAK THEIR NATIVE LANGUAGES ONLY	▪ Through interpreters. (qnr7) ▪ Use escorts who accompany them to clinic. (qnr 18) ▪ Use other immigrant patients who speak that language. (qnr 12) ▪ Use signs. (qnr29) ▪ Use assumptions in worst cases. (qnr 23)

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4.3.2.3 INTERPRETOR SERVICES AND LANGUAGES THEY INTERPRET

FIGURE 16: What languages they could interpret

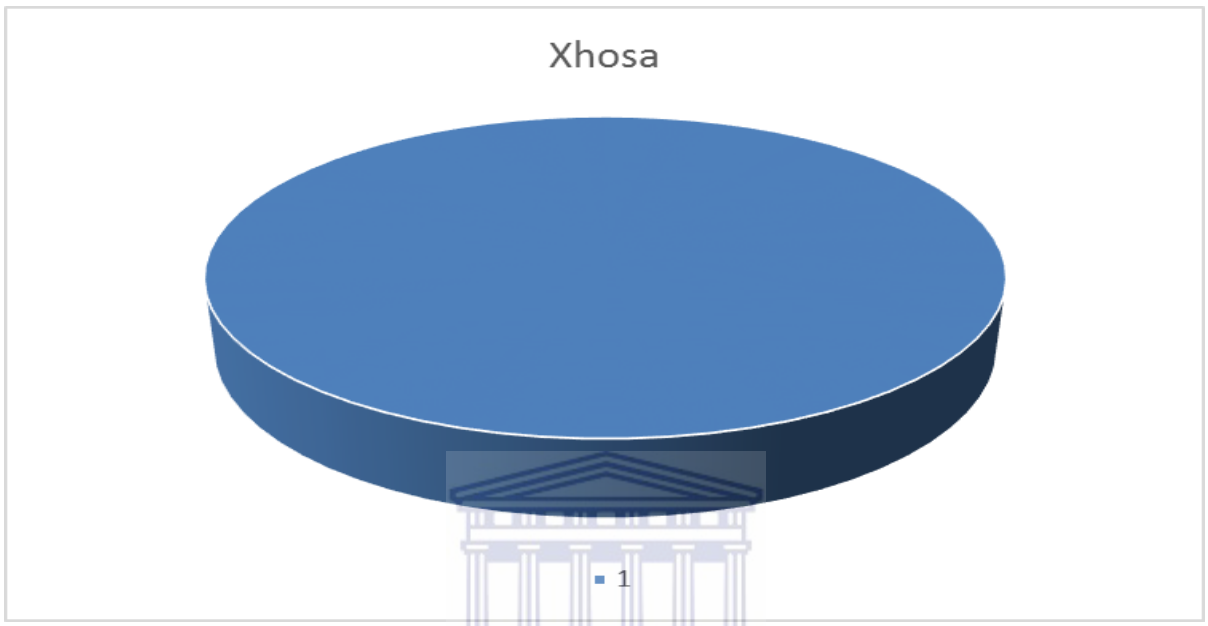

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Figure 16, refers to questions thirteen and fourteen. Thirty percent of the medical personnel indicated that they have interpreter facilities and for those who said they have interpreter facilities all of them indicated that the facilities can interpret IsiXhosa. Interpreter services are a welcome relief in a situation of a communication problem, but it is the effective use of this service that makes it important and failure to use it properly may also result in creation of further communication barriers to accessing public health care. Lamb and Smith (2007) argue that it is not only the absents of interpreter services that creates a barrier to the provision of public health care service to immigrant populations but the effective use of it as well. They said while a free telephone interpreter service exists for medical practitioners many doctors are reluctant to use it. This non-use of interpreter service may create barriers of access to public health care to immigrants' patients who may need it as a last resort so that they may be afforded effective public health care services.

4.3.2.4 FREQUENCY OF SERVING IMMIGRANTS AT PUBLIC HEALTH FACILITIES.

FIGURE 17: Frequency of serving immigrant patients

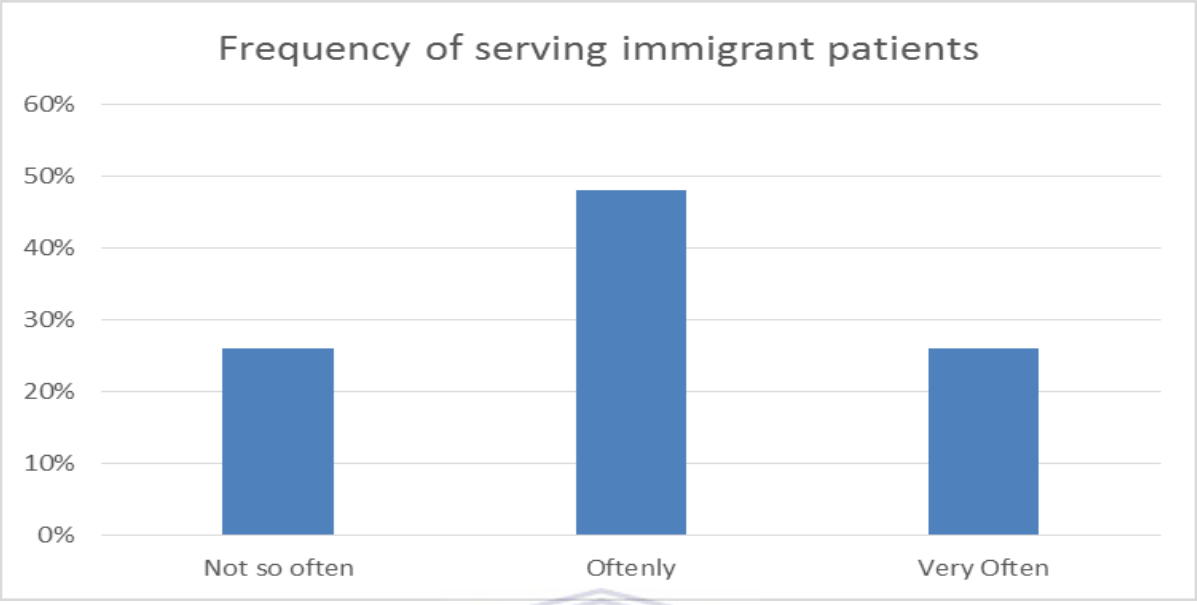

Figure 17, refers to question fifteen. Medical personnel responded to frequency of serving immigrant patients. Twenty six percent responded saying not so often, forty-eight percent said often, and twenty-six percent said very often. The increase in the number of immigrants at public health care facilities can be linked to Landau (2007) who states that there was a serious increase in the rate of immigrant inflows into South Africa as a result of different push and pull factors from other countries.

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4.3.2.5 DENIAL OF IMMIGRANTS ACCESS TO PUBLIC HEALTH CARE.

FIGURE 18: Denial of medical service

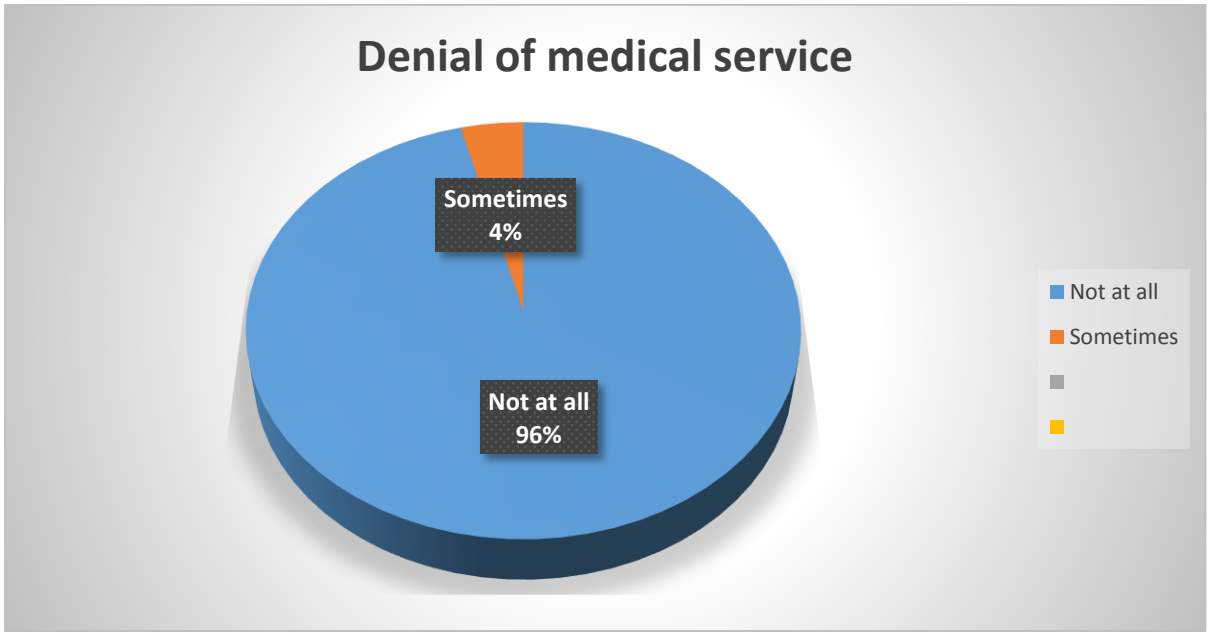

Figure 18, refers to question 16 and 17 and the medical personnel were responding to whether they had denied any immigrant access to public health care and why? Ninety-six percent indicated that they had not, whilst four percent indicated that they did. For those who said yes the reason was that the immigrants had no required documentation. The response from medical personnel in this regard do not reflect what literature shows, Literature shows that a lot of immigrants have been denied access to public health care even if they had the required documentation as cross-border migrants face challenges in accessing public health care services despite the presents of protective legislation, identity documents cannot prevent discrimination or ensure social inclusion (Landau, 2007). Palitza (2008) observed cases where foreign nationals have been refused treatment in clinics by nurses and doctors who were not aware of the law.

4.3.2.6 PREFERENTIAL SERVICE TO CITIZENS OVER NON CITIZENS

FIGURE 19: Preferential treatment

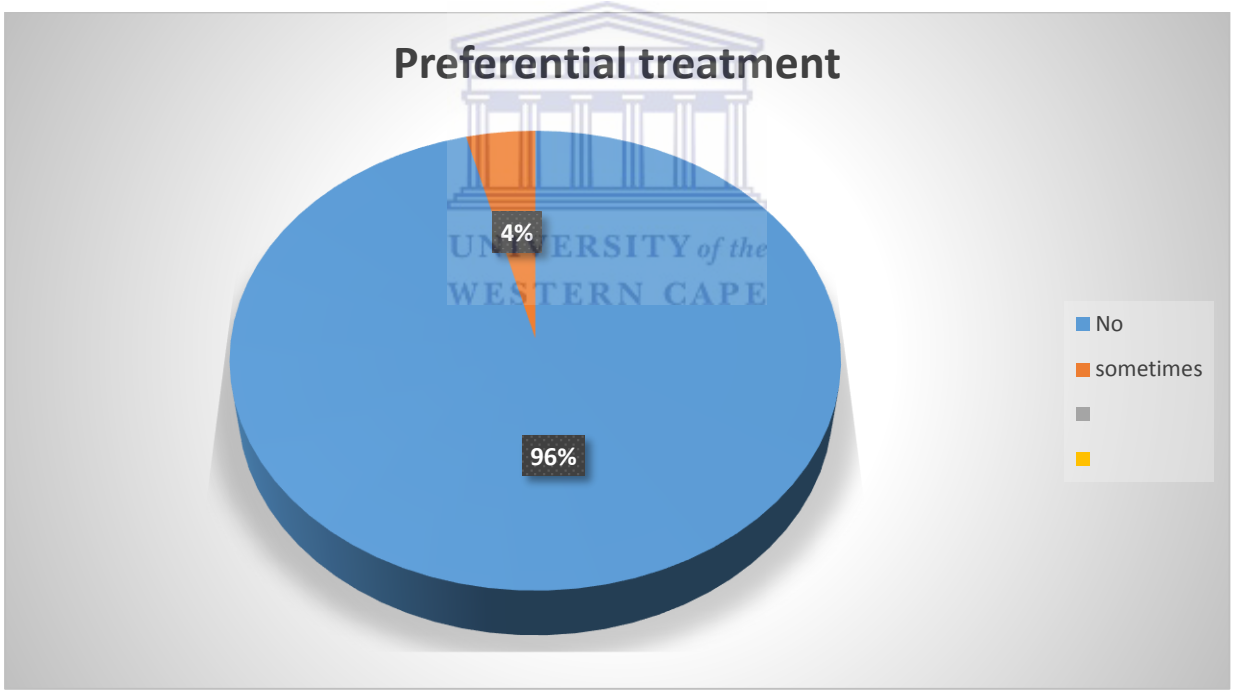

Figure 19, refers to question 18, which asked the medical personnel whether they offer preferential service to citizens over non-citizens. Ninety-six percent of them said not at all and four percent said at times. The responses here also differ from what literature picked up, Literature depicts medical personnel as xenophobic and anti-immigrant even in other countries besides South Africa the trend is more or less the same. Cross border migrants are generally viewed as placing an unnecessary burden on all social services in general and public health care systems in particular (Worth, 2006). Racial and cultural discrimination towards immigrants can also act as a barrier in access to health care services.

4.3.3 MEDICAL PERSONNEL POLICY KNOWLEDGE AND GOVERNMENT INTERVENSIONS.

4.3.3.1 MEDICAL PERSONNEL KNOWLEDGE OF POLICY AND PRACTICE ABOUT IMMIGRANTS ACCESS TO HEALTH.

FIGURE 20: Knowledge of policy on immigrants' access to health care

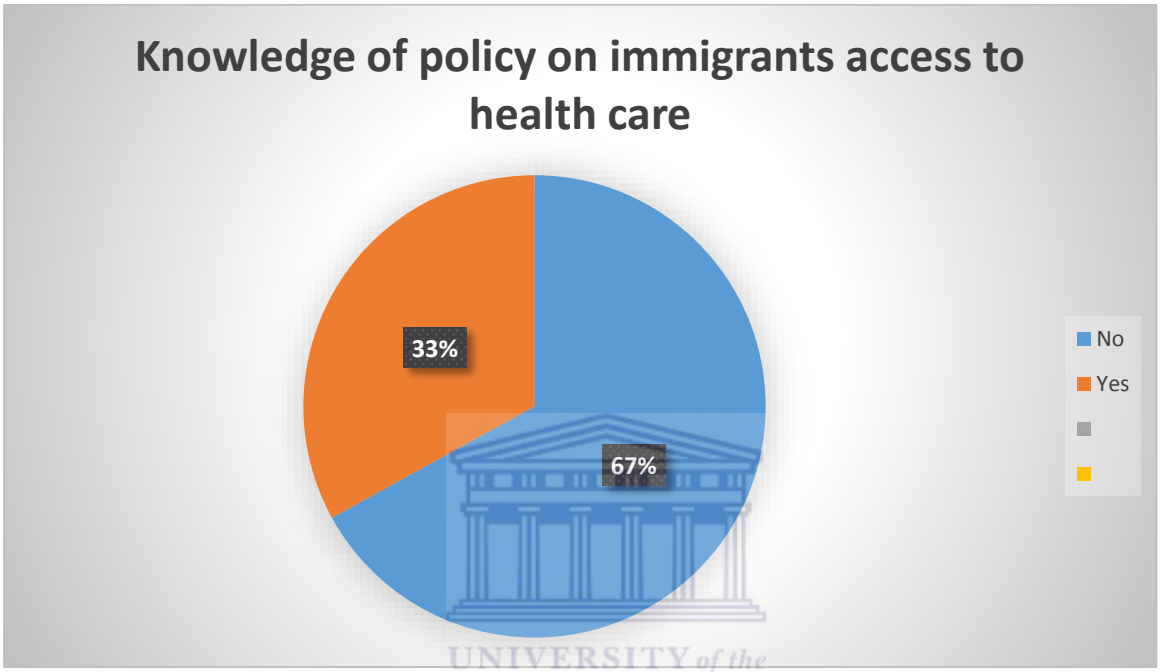

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Figure 20, refers to question nine-teen. Thirty three percent of medical personnel indicated that they knew the policy and sixty-seven percent said they did not know what the policy says.

FIGURE 21: Policy and Practice

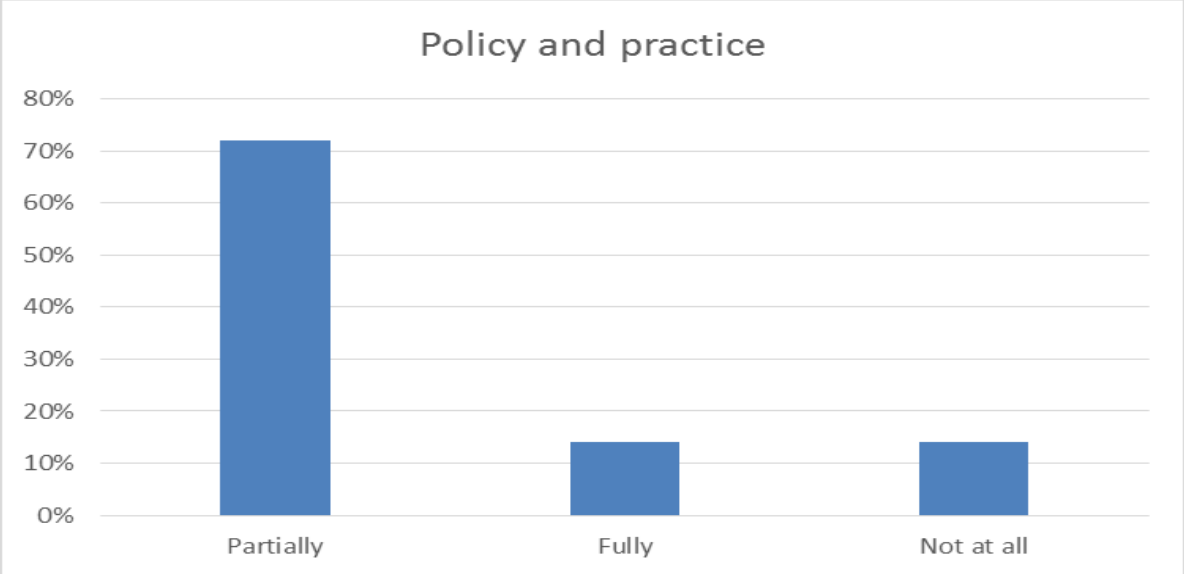
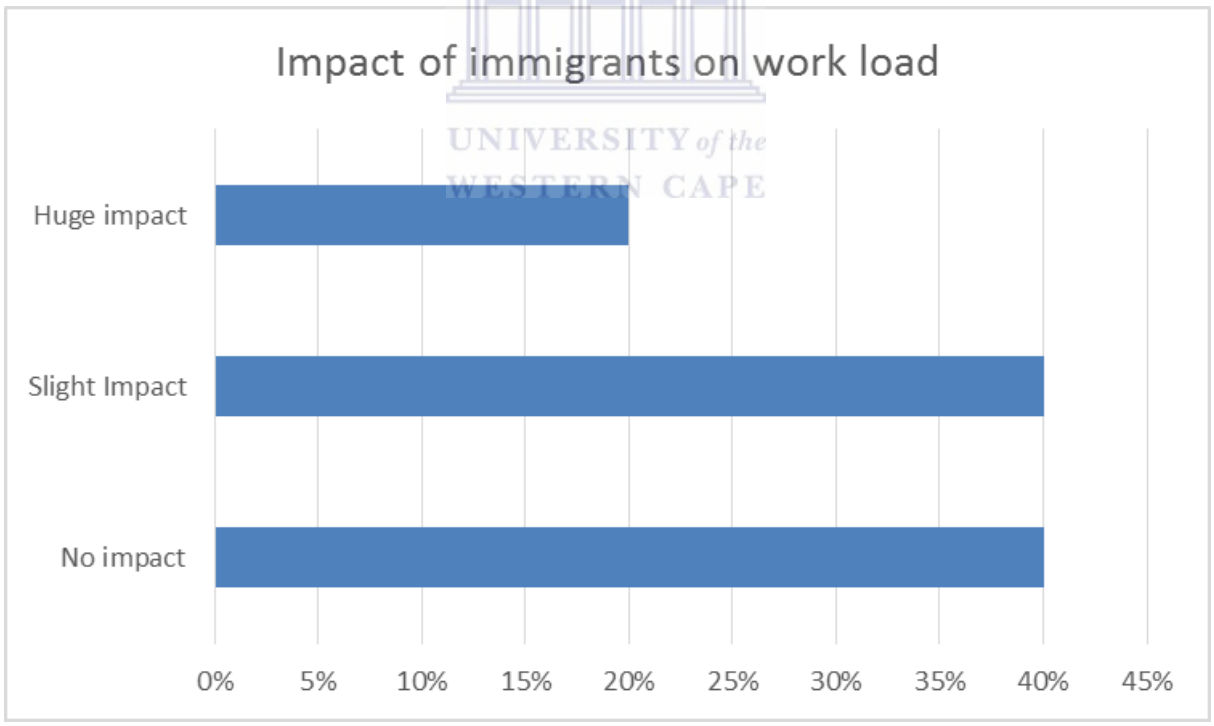


Figure 21, refers to question twenty, for those medical personnel who indicated that they knew the policy on health care for immigrants, fourteen percent said it was not practiced at all, seventy-two percent said it was partially put in practice and fourteen percent said it was fully practiced.

Lack of knowledge on what policy says on immigrants 'access to health care and subsequent failure to practice what the policy says contributed to the existence of barriers to access to health care for immigrants. Palitza (2008) observed cases were foreign nationals have been refused treatment in clinics by nurses and doctors who were not aware of the policy and law. CORMSA (2008) reports that some of the public clinics and hospitals have continued to deny immigrants access to antiretroviral therapy despite the 2007 directive by the national department of health that the possession of a South African identity booklet is not a prerequisite for eligibility for antiretroviral therapy. In this case lack of policy knowledge and failure to practice it when you have knowledge causes barriers to access public health care.

4.3.3.2 IMPACT ON WORK LOAD AS A RESULT OF IMMIGRANTS USING PUBLIC HEALTH CARE FACILITIES.

FIGURE 22: Impact of immigrants on workload



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Figures 22, refers to question twenty four, in which medical personnel responded to the question on impact of work load which is caused by the use of public health care facilities by immigrants. Forty percent of the medical personnel said it had no impact at all, the other forty percent said it caused slight impact and twenty percent said it caused a huge impact. If medical personnel work with the perception

that immigrants cause them to have an increased work load chances are that they may end up serving immigrants with a negative attitude which also affects the level and quality of treatment that they will get as they view immigrants as placing an unnecessary burden on all social services in general and public health care systems in particular (Worth, 2006).

4.3.3.3 ABILITY OF INSTITUTIONS TO BE ABLE TO ASSIST ALL IMMIGRANTS THAT REQUIRED MEDICAL SERVICES.

FIGURE 23: Ability to assist all immigrant patients

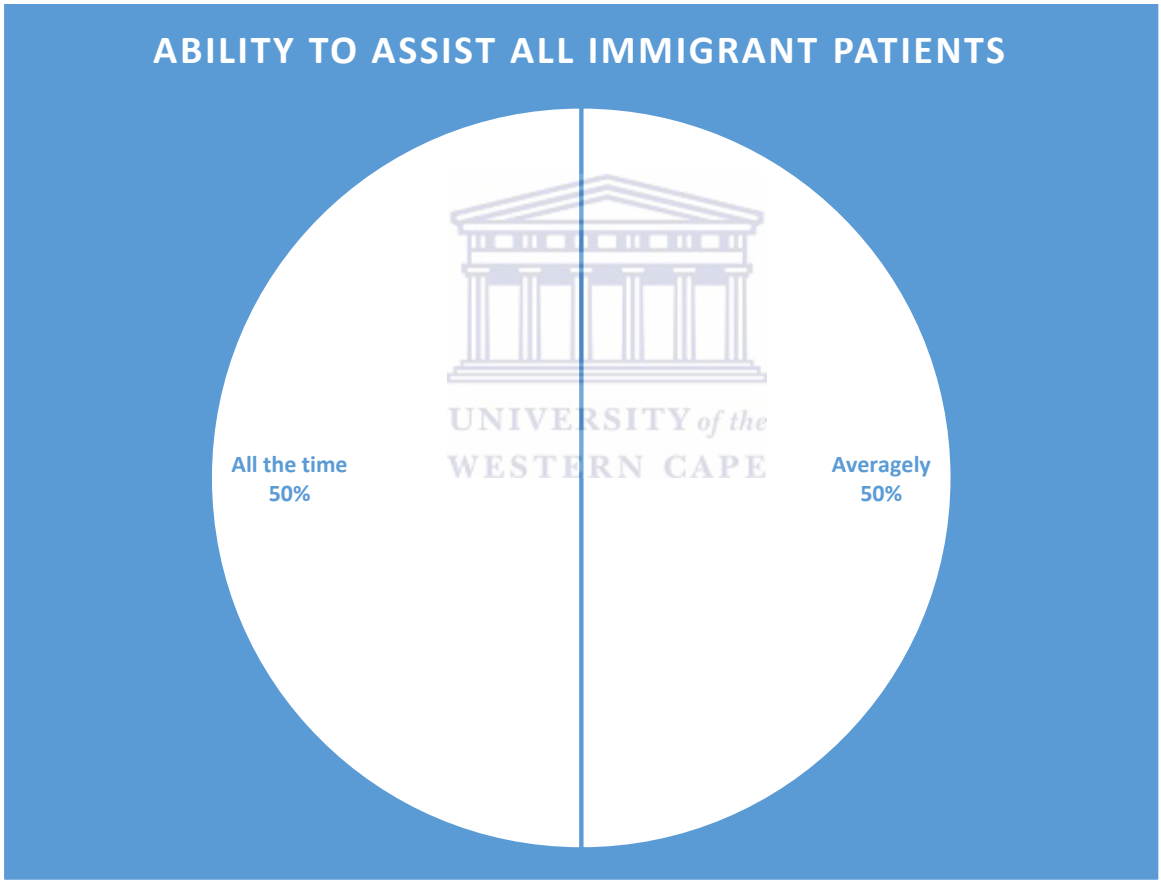

Figure 23, refers to question 22, and medical personnel responded to the question on institutions being able to assist all immigrants that use public health facilities with fifty percent saying average and the other fifty percent saying they are able to all the time.

4.3.3.4 PERCEPTION ON SOUTH AFRICAN GOVERNMENT ASSISTING IMMIGRANTS

FIGURE 24: Perception of South African government assisting immigrants

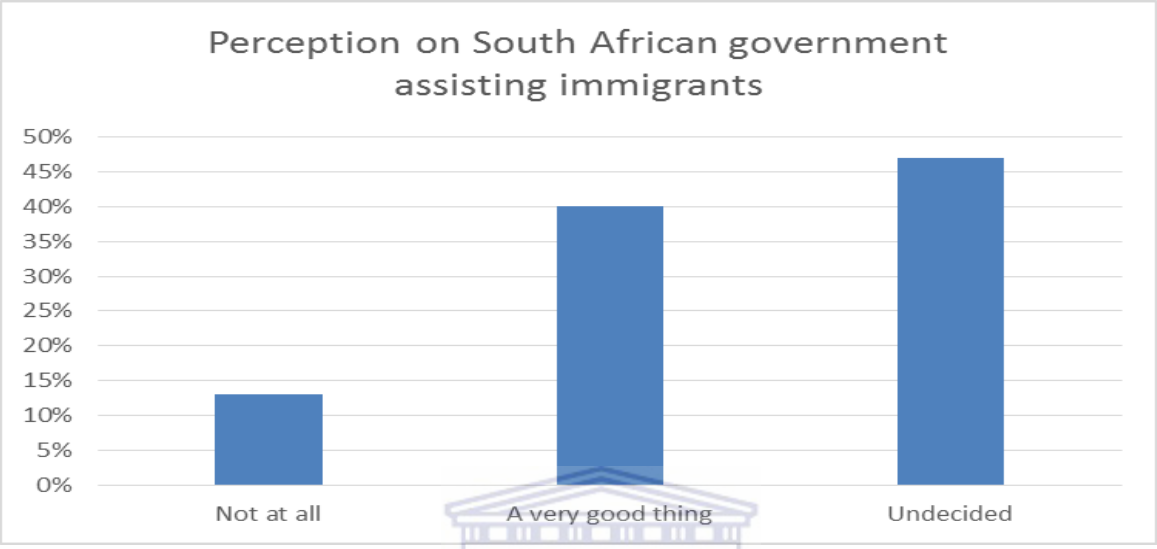

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Figure 24, refers to question 23. When asked whether it was good thing for South African government to assist immigrants with public health care, thirteen percent said not at all, forty percent said it was a good thing and forty-seven percent were undecided.

4.3.3.5 RESOURCES FROM DEPARTMENT OF HEALTH

FIGURE 25: Is Department of health able to provide resources needed for work

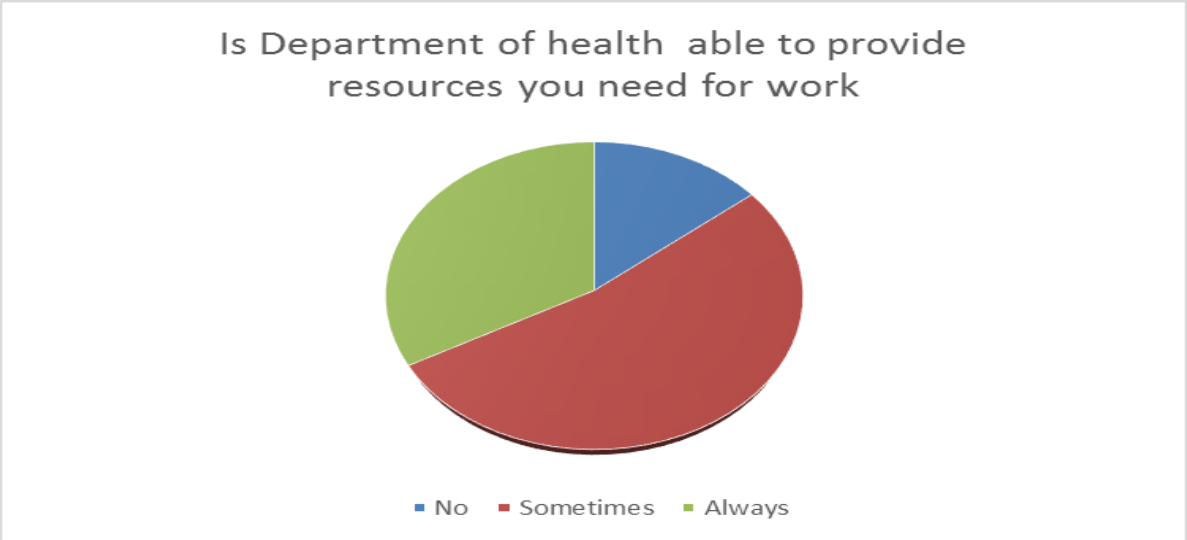

Figure 25, refers to question 25. The medical personnel were asked whether Department of Health was able to provide institutions with resources they needed to execute their jobs, fourteen percent said no, fifty-three percent said sometimes and thirty three percent said always.

Table: 10 Biographical information of Zimbabwean immigrants that participated in semi-structured interviews

PARTICIPANT	GENDER	AGE	MARITAL STATUS	YEAR OF ARRIVAL	IMMIGRATION STATUS	REASONS FOR IMMIGRATION
1	MALE	33	MARRIED	2007	ASYLUM SEEKER	ECONOMIC -WORK
2	MALE	34	MARRIED	2008	PASSPORT-VISA	ECONOMIC -WORK
3	MALE	58	MARRIED	2006	ASYLUM SEEKER	ECONOMIC -WORK
4	FEMALE	26	MARRIED	2007	UNDOCUMENTED	ECONOMIC -WORK
5	FEMALE	34	SINGLE	2007	ASYLUM SEEKER	ECONOMIC -WORK
6	FEMALE	28	MARRIED	2006	REFUGEE STATUS	ECONOMIC -WORK
7	MALE	29	MARRIED	2008	REFUGEE STATUS	ECONOMIC -WORK
8	FEMALE	26	SINGLE	2009	ASYLUM SEEKER	ECONOMIC -WORK
9	FEMALE	30	MARRIED	2009	WORK PERMIT	ECONOMIC -WORK
10	FEMALE	32	MARRIED	2009	SEASONAL PERMIT	ECONOMIC -WORK
11	MALE	23	SINGLE	2009	WORK PERMIT	ECONOMIC -WORK
12	MALE	35	MARRIED	2008	UNDOCUMENTED	ECONOMIC -WORK
13	MALE	26	SINGLE	2009	ASYLUM SEEKER	ECONOMIC -WORK
14	MALE	38	MARRIED	2008	ASYLUM SEEKER	ECONOMIC -WORK
15	FEMALE	27	MARRIED	2006	ASYLUM SEEKER	ECONOMIC -WORK
16	FEMALE	31	MARRIED	2009	ASYLUM SEEKER	POLITICAL
17	FEMALE	25	DIVORCED	2009	PASSPORT-VISA	ECONOMIC -WORK
18	FEMALE	27	MARRIED	2008	ASYLUM SEEKER	ECONOMIC -WORK
19	MALE	30	MARRIED	2006	ASYLUM SEEKER	POLITICAL
20	MALE	24	SINGLE	2009	STUDY PERMIT	EDUCATIONAL
21	FEMALE	36	MARRIED	2006	REFUGEE STATUS	POLITICAL
22	MALE	29	MARRIED	2007	ASYLUM SEEKER	POLITICAL
23	MALE	20	SINGLE	2009	STUDY PERMIT	EDUCATIONAL
24	FEMALE	32	MARRIED	2009	SEASONAL PERMIT	ECONOMIC -WORK
25	FEMALE	27	MARRIED	2009	PASSPORT-VISA	ECONOMIC -WORK
26	MALE	31	MARRIED	2005	SEASONAL PERMIT	ECONOMIC -WORK
27	MALE	28	SINGLE	2006	ASYLUM SEEKER	ECONOMIC -WORK
28	FEMALE	28	SINGLE	2008	WORK PERMIT	ECONOMIC -WORK
29	FEMALE	35	MARRIED	2007	WORK PERMIT	ECONOMIC -WORK
30	MALE	22	SINGLE	2009	STUDY PERMIT	EDUCATIONAL

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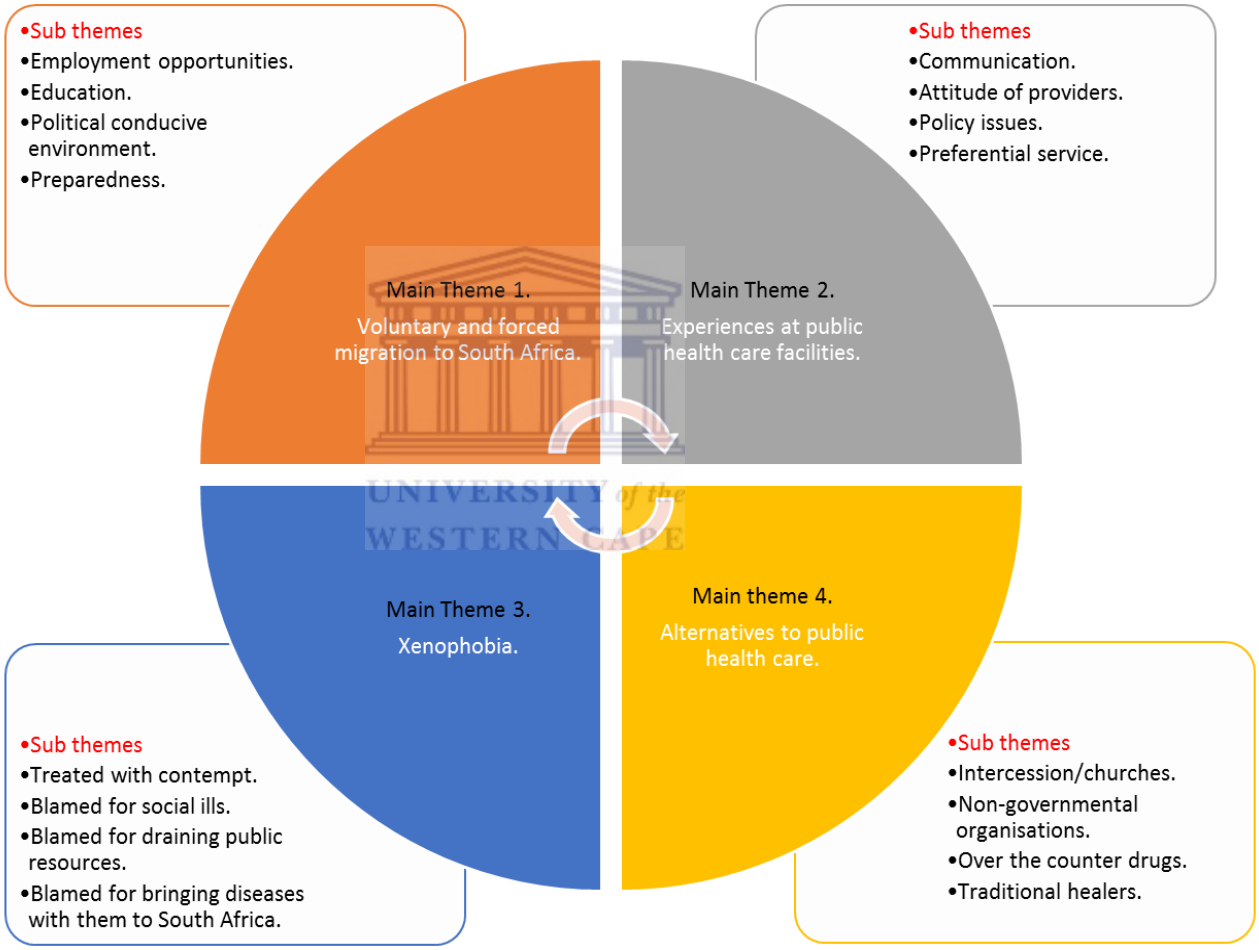
4.4 FINDINGS FROM SEMI-STRUCTURED INTERVIEWS CONDUCTED ON ZIMBABWEAN IMMIGRANTS.

The themes and sub-themes that came out of the research through semi-structured interviews were voluntary and forced migration from Zimbabwe to South Africa, experiences of Zimbabwean immigrants at public health care facilities, xenophobia and alternatives to public health care. Several sub-themes also emerged from these main themes.

FIGURE 26: Themes and sub-themes from the study



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4.4.1 VOLUNTARY AND FORCED MIGRATION INTO SOUTH AFRICA FROM ZIMBABWE.

4.4.1.1 Employment opportunities

Most Zimbabwean immigrants indicated that migration into South Africa was forced as result of the economic environment in Zimbabwe which forced them to leave the country. Most of them had lost

their jobs coupled with the hyperinflation of the local currency. The economic environment was so unbearable that they had to look for options to save themselves and South Africa being the economic powerhouse of the region was the only destination that they could see their dreams being fulfilled. They indicated that presents of other family members that had already migrated into South Africa and settled offered them a sense of hope as they realised that they could also settle down like the other family members who had secured employment. They however also did not rule out the fact that employment was not only going to come on a silver plate, but hopes were very high that is why they immigrated into South Africa.

4.4.1.2 Political environment

The other Zimbabweans immigrants indicated that they were forced to leave the country as result of hostile political environment. They blamed the Government for orchestrating violence against citizens that opposed the undemocratic tendencies. Which included beatings, killings and torture of any people who opposed the government. These immigrants were of the opinion that South Africa was safer destination where they could voice their opinions against the Zimbabwean government without fear, thus a few indicated that they are members of the opposition Zimbabwean political parties with branches in South Africa.

4.4.1.3 Educational purposes

A few Zimbabwean immigrants that were interviewed were students. They indicated that they voluntarily came to South Africa to further their studies at South African universities because of the programmes that they offered and availability of places. They however also indicated that though they voluntarily migrated to study but there were some elements of forced migration since Zimbabwean university system was being affected by lack of funding and continued strikes that disturbed the smooth flow of learning.

4.4.1.4 Preparedness and Social Linkages

All the participants in the study indicated that they knew someone who was already based in South Africa from Zimbabwe before they immigrated into South Africa. Social linkages that existed between those Zimbabweans who had already settled in South Africa and the potential migrants who were still in Zimbabwe made the whole immigration to be easy as they had forerunners that had paved the way for them. Students P-20,P-23, P-30 indicated that the family members who were already settled in South Africa and other colleagues who were already in universities did actually initiated the move by inviting them to South Africa where economic and educational opportunities were better. They claimed that the social linkages made their preparations to relocate to be easy and settlement in South Africa smooth.

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4.4.2 EXPERIENCES AT PUBLIC HEALTH CARE FACILITIES

4.4.2.1 Communication

Zimbabwean immigrants indicated that in most cases they experienced communication problems at the public health facilities they used. This communication problem experienced was in different forms. P-3, indicated the nursing sister who was responsible for giving out information of who should go where was only speaking in IsiXhosa and this affected the participant as he participant was confused and did not know what to do. Some immigrants indicated that when they used English to communicate with the staff at the point where patients collect their folders, the staff responded in a local language that made them not to understand P-14 and P-16. P-6 indicated that at one hospital a form written in Afrikaans was issued to the participant to put some biographical information so that they could open a folder, the participant asked for one written in English but was told that they were finished and a fellow patient who understood Afrikaans interpreted for the participant so that the participant could complete the form. P- 27, indicated that the nurse who assisted the participant continuously mixed English and IsiXhosa such that the participant did not understand parts of their medical conversation.

4.4.2.2 Attitudes of providers of health care.

Participants indicated many instances where the providers of public health care were very rude to the immigrants. Some participants indicated that since communication was a problem, they tried to speak in local languages, P-11 indicated a situation where the nurse told the participant to keep quite because the participant was mocking the language from the way the participant was speaking the language. P-5 referred to the nurse as her sister and was told to stop that as she was not her sister and that her sisters were at home. Instances of arrogance, unfriendliness and hostility were indicated by most participants in the study they branded some nursing sisters as extremely rude people.

4.4.2.3 Preferential treatment of locals over immigrants.

Zimbabwean immigrants indicated also situations in which preferential treatment was offered to citizens over non-citizens. P- 19 described an instance in which the participant went to the public health facility very early in the morning and was number three on the queue. When it was opening time those with South African Identity documents were served first and those that had other documents were served last despite what time they arrived at the facility. Preferential treatment was also benefiting citizens over non-citizens as instructions to go to certain rooms or follow a certain queue were given in local languages this led to locals to move faster than immigrants as immigrant did not know what to do and had to be assisted with some local who had to interpret for them. One immigrant P-19, also explained an instance in which one immigrant lady followed a wrong queue for almost three hours because she had misunderstood the instruction which was given in IsiXhosa.

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4.4.2.4 Policy and Practice

Experiences of other Zimbabwean immigrants at public health care facilities depicted the existence of disjuncture between policy and practice. Policy says that nobody should be denied access to public health care because of failure to produce, proof of residence and that a South African identity document is not a prerequisite for accessing anti-retroviral therapy. Some immigrants have been denied access to public health care because of not having proof of residents P-18. Some have been denied access to public health care even if they had documents because the frontline staff did not accept documents such as asylum permit P-22.

4.4.3 XENOPHOBIA

4.4.3.1 Treated with contempt.

Foreigners of African origin in South Africa are treated with contempt because of xenophobia. Zimbabwean immigrants indicated that they have been victims of xenophobia in South Africa, from other African, South Africans. P-1, gave an incident where immigrants have been accused of bringing diseases into South Africa from their countries and if they are sick they need to go back and die there.

4.4.3.2 Blamed for social ills.

Zimbabwean immigrants have indicated that as they reside in the same communities with South Africans they are accused of contributing to a lot of social ills. In informal discussions with locals they have accused foreigners of committing crimes, prostitution and taking jobs and this has been cemented by local media.

4.4.3.3 Blamed for draining resources

Participants also indicated that xenophobic tendencies amongst many African locals led to the immigrants in general including Zimbabweans to be blamed for draining local resources that are also depleted as a result of intensive use by many marginalised citizens. They indicated that even at public health care facilities, some members of the medical personnel view them in that fashion.

4.4.4 ALTERNATIVES TO PUBLIC HEALTH CARE

4.4.4.1 Intercession

There was indication from the participants that even if they received medical assistance from public health care facilities they complemented their medicalization process with intercessions by their church pastors or senior church members.P-2 indicated that some immigrant colleagues close to the participant when they were denied access to public health care because of some reasons they end up going to churches to be interceded upon by pastors.

4.4.4.2 Over the counter drugs

Over the counter drugs were mentioned by immigrants as another alternative to take in the event that accessing public health care was a problem or was risky in terms of immigrants that do not have proper documentation because if they would access public health care they would risk being reported to the police or Department of Home Affairs that could deport them.

4.4.4.3 Traditional healers

Immigrants also mentioned that, in the immigrant communities most African people have a strong belief in the use of traditional medicines that they believe are able to cure ailments that they refer as African ailments that are caused by spirits. This alternative to public health care was used by those who believed the ailments they had were not curable with modern medications.

4.4.4.4 Non-governmental organisations

Some of the immigrants in the study indicated that some Zimbabwean immigrants that they knew as a result of their social linkages indicated that when they went to public health care facilities to access anti-retroviral therapy they were denied as a result of them being non-citizens and the programme was for citizens only. They ended up going to non-governmental organisations such as CORMSA that assisted mainly immigrants with HIV and AIDS with or without documentation.

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4.5 FINDINGS FROM SEMI-STRUCTURED INTERVIEWS RAW DATA.

TABLE 11: Findings from semi structured interviews

MAIN THEMES	SUB-THEMES	SELECTED EXAMPLE OF RAW DATA
Voluntary and forced migration from Zimbabwe to South Africa	Employment opportunities	• I came in search of greener work pastures. (P-1) • I came to look for employment. (P-4, P-11) • I came because I was looking for better paying employment. (P-8, P-9, P-10)

		• I came to work. (P-26)
	Stable political environment	✓ Running away from political problems in Zimbabwe. (P-16) ✓ Ran away from political turmoil. (P-19) ✓ Came because of political stability in South Africa. (P-15, P-21) ✓ Running away from hostile political climate. (P-22)
	Education	▪ I came down South because of better educational environment. (P-20) ▪ Relocated for a chance to further my education. (P-23) ▪ To further my education. (P-30)
	Preparedness and social linkages	• My brother was in South Africa already so it was not difficult to come. (P-20) • A few of my family members were already here and they encouraged me to come then, I decided to come. (P-23)
Experiences at public health facilities.	Communication	✓ All the patients at the clinic were addressed in IsiXhosa and this created a problem for us immigrants who did not understand the language. (P-3) ✓ I ended up not understanding what she was saying. (P-9)

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		✓ They gave me a form to complete, but it was in Afrikaans, I asked for the one in English, they said there were finished so one patient who understood Afrikaans, assisted me in completing the form. (P-6)
	Attitude of providers of public health care.	▪ I tried to talk to the nursing sister in IsiXhosa she told me to keep quiet as I was mocking their language from the way I was speaking. (P-11) ▪ I referred to the nurse as my sister in a respectable way but she said I was not her sister her sisters were at home. (P-5) ▪ The clinic staff was very rude. (P-24)
	Policy and practice	• When I was at the registration point the clerk asked me to give her proof of residence which I did not have so I was told to go back home and bring it so that they could assist me. (P-18) • I was asked for my identification so I gave the lady my asylum permit, she looked at it and said that it was not acceptable, I had to go away. (P-11)
	Preferential treatment	▪ I was number one at the queue ,but when it was time to be served they assisted

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		those people who hand South African identity document first and I was served well after because I am a non-citizen. (P-19) ▪ The lady that was next to me who was also an immigrant followed a wrong queue for some time because she did not understand the instructions that were given in a local language she just Assumed. (P-19) ▪ As the people were standing outside at the clinic one nurse came to give instructions of service but that was done in IsiXhosa and this deprived the immigrant population as they did not understand what was taking place. (P-3)
Xenophobia	Treated with contempt	▪ Was told by a South African colleague in an informal discussion that foreigners bring diseases with them that could also affect locals. (P-1)
	Social ills	• I was blamed for being part of the immigrant population who contribute in a lot of social ills that have rocked

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		communities such as violent crimes, prostitution and peddling of drugs. (P-22, P- 14, P-28)
	Draining resources	✓ When I was at a local hospital we were speaking in our local language, then we overhead two males talking on how the immigrants have left their countries and come to put pressure on local resources and they drain them disadvantaging the citizens. (P-7)
Alternative to public Health care.	Churches/intercession	▪ I believe that even if I go to the hospital or clinic and get medication, my pastor has to pray for that medication and for me so that the medication my work well. (P-29) ▪ Yes I know of two friends who were denied access to public health care and they had to go to their church pastors to pray for them to get well and to remove bad luck. (P-2)
	Non-governmental organisations.	• I know of people close to me who were denied access to anti-retroviral therapy because there were non-citizens , they had

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		to go non-governmental organisations for assistance. (P-17)
	Traditional medication	✓ They told me that they were going to a traditional healer because the disease was not curable with modern medication but in the traditional way. (P- 10)
	Over the counter medication	▪ When your papers are not right you do not risk to go to the clinics because you can be arrested so over the counter drugs is a less risk route in terms of being arrested. (P-4)

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CHAPTER FIVE

DISCUSSIONS CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The main purpose of the research study was to uncover the Zimbabwean immigrants' experiences at selected public health care facilities in Cape Town. For the study to unpack these experiences, Zimbabwean immigrants' experiences were investigated using qualitative investigation technique of semi-structured interviews that illuminated the first hand experiences of the participants. Semi structured interviews were conducted and transcribed into main themes and sub-themes as presented in Chapter four of the study. Questionnaires were also administered on both the Zimbabwean immigrants and medical personnel to further unpack the Zimbabwean immigrants' experiences and also to uncover the reactions from medical personnel as they encountered immigrant patients at their facilities. Questionnaires were statistically analysed using the Micro soft excel package of data assessment where descriptive statistics were presented in the form of tables, pie diagrams and histograms and are presented in the preceding chapter, and the open-ended questions in the questionnaires were qualitatively analysed using content qualitative analysis into main themes and sub-themes. Foucault's theory on knowledge and power was used to illuminate the experiences of the immigrant patients and the subsequent behaviour of medical personnel as they encountered Zimbabwean immigrants.

5.2 VOLUNTARY AND FORCED MIGRATION

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Africans have always been on the move (Akokpari, 1998) and there are indications that this mobility is on the rise as migration has become a global phenomenon in this century. These migrants include generally voluntary migrants and forced migrants which are mainly refuges and asylum seekers. It is noted by (Landau, 2007) that South Africa is the SADC member state with highest rates of internal and cross border migration. This phenomenon of receiving large numbers of people who come to seek refuge as a result of push factors that make them leave their native countries and pull factors that attract them to South Africa results in the increase in the numbers of immigrant arrivals as stated that the continued arrivals of immigrants in their large numbers especially undocumented immigrants has negative impact on the provision of social services and the South African society at large.

5.2.1 EMPLOYMENT OPPORTUNITIES

Seventy percent of the participants from the questionnaires came to South Africa because of employment opportunities that prevailed, Data from the questionnaires also shows that seventy four percent of immigrants survived on working which qualifies the assertion that most Zimbabwean immigrants in South Africa were economic migrants. Findings from the interviews also indicate that most of the Zimbabweans who came to South Africa came for economic needs. P-1, P- 4, P-8, P-9, P-

10, 11, P- 26 indicate that their main reason for coming to South Africa was to look for employment which was not readily available in Zimbabwe because of poor economic conditions, This supports the assertion that more Zimbabweans immigrants were economic migrants because of their said primary purpose of immigrating to South Africa. On the other hand eighty percent of the Zimbabwean immigrants had applied for asylum or were already granted refugee status. Vearey & Ritcher (2008) noted that the South African immigration act makes it difficult for lower skilled workers to legitimize their stay. Most of these Zimbabwean immigrants fall into the lower skilled category which makes them ineligible for most if not all the permits that allow them to legally work and conduct business in South Africa. They were left with few options to legalise their existence in South Africa which was to seek asylum or ending up hibernating as undocumented immigrants. South Africa adopted an integrative asylum policy where asylum seekers and refugees are encouraged to self-settle and integrate in the main stream South African society. A range of rights are afforded which include rights to access all social services including rights to education and work Vearey & Ritcher (2008). Most Zimbabwean applied for asylum seeking permits so as to legitimize their stay and to enhance their eligibility to access the basic social services such as access to public health care and education as spelt out in the Geneva Convention of 1951.

5.2.2 POLITICALLY CONDUCIVE ENVIRONMENT

Seventeen percent of the Zimbabwean immigrants indicated that there were forced out of Zimbabwe by the economic and political situation which was not conducive for them. Wentzel, Viljoen & Kok (2006) point out that many Zimbabwean immigrants indicated that political tension and marginalization of minority ethnic groups were factors that encouraged their migration to South Africa. HRW (2008) made similar claims that unlike previous migration between the two countries where Zimbabwean migration was circular the migration between 2005 and 2008 has been increasingly motivated by the persecution of Zimbabweans under Mugabe regime in the form of arbitrary arrests and detentions, torture and beatings and government orchestrated violence in the wake of March 29 elections. Zimbabwean immigrants decided to come to South Africa because of perceived conducive political environment which was democratic. They ended up joining branches of Zimbabwean opposition parties in South Africa, because it was not risky to do it in South Africa as compared to engage in political activities in Zimbabwe.

The movements of Zimbabwe immigrants to South Africa can also be further elaborated by Foucault's theory on power relations. State institutions and political parties used power to control the people, but the productiveness of this power relationship was illuminated when the people resisted to the political ideology and practices of the state thereby engaging in new forms of behaviour which was migrating to South Africa to enhance their political careers where there was no danger to carry out such activities.

5.2.3 PREPAREDNESS AND SOCIAL LINKAGES

There has been a long history of the immigration of Zimbabweans into South Africa. This dates back to many years, but the most remarkable period was when gold was discovered in the Transvaal area and diamonds in the Kimberly area. There was need for manpower to work in the mines and neighbouring countries such as Zimbabwe provided the required labour through institutions such as Witwaters Native labour Association which brought in people from other regional countries into South Africa. A remarkable movement of Zimbabweans into South Africa emerged, Crush & Tevera (2006) made similar claims that migration between Zimbabwe and South Africa is nothing new, in the colonial period Zimbabweans migrated to work in the mines in South Africa. Over the years the social networks of Zimbabweans in South Africa have grown as many people had social networks and linkages extending from Zimbabwe to South Africa and vice versa, these networks made communication between Zimbabweans in South Africa and those in Zimbabwe to be easy. Those Zimbabweans immigrants who were already settled in South Africa acted as yardsticks used to weigh one's chances of success when they decide to immigrate. The social linkages helped those migrants in Zimbabwe to be prepared to immigrate to South Africa because of social networks of family or friends that had already settled in South Africa, a quarter of adult Zimbabweans have parents and grandparents who have worked in South Africa at some point (Crush & Tevera 2006).

5.3 EXPERIENCES AT PUBLIC HEALTH FACILITIES

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All the Zimbabwean immigrants that participated in the study had fallen sick at some point during their stay in Cape Town such that they had to seek medical services from a public health care facility. The conditions associated with migration and the poor well-being of migrants made them vulnerable to disease in general and HIV infection in particular especially women. Being a cross-border migrant severely limits one's access to public services such as sanitation, education, banking and health care, place of residence is also a contributing factor to access to decent housing and sanitation (IOM, 2013). Migrant populations, both internal and cross-border are largely concentrated in poor urban and peri-urban areas. Separation of immigrants from members of their families render them susceptible to infectious and communicable diseases including STDs and HIV/AIDS. Having left their home countries, and left behind relatives, friends, possessions, traditional routines and value systems and abandoned conventional ways of behaving in their home countries and adapting to poor ecological problems in most cases resulted in them falling sick despite the fact that cross-border migrants rate their health status as higher than that of locals, this may be due to the fact that generally only physically healthy individuals will migrate (IOM, 2013).

5.3.1 COMMUNICATION

Zimbabwean immigrants were also affected by communication problems just like any other foreign nationals as they were also affected by say instructions given in local languages, even though most of

them speak English, it is not their first language and they may struggle to explain their inner feelings very well and ask questions to the medical personnel. Crush & Tawodzera (2011) also made similar claims that majority of Zimbabwean immigrants indicated that their most common problem with South African health service was language related with exception of Ndebele and Venda which are spoken in some parts of Zimbabwe, most South African languages are not easily understood by Zimbabwean immigrants. P-3 from the interviews indicated that instructions at the public health centre were given in IsiXhosa. P-9 also talked about how the nurse mixed English and IsiXhosa such that the patient ended up not understanding anything. The questionnaires also indicated that eighty percent of the Zimbabwean immigrants had experienced communication problems at public health care facilities. Foucault in his theory of knowledge and power talked about knowledge being inextricably entwined with relations of power and advances in knowledge being associated with advances and developments in the exercising of power. Medical personnel employed the power that they had in addressing and talking to the immigrant patients in the languages of their choice, but the knowledge that immigrants had in terms of their access to public health care also produced power as indicated in the questionnaire that eighty three percent of the immigrants had knowledge on what policy on health care says about immigrants so according to Foucault this relationships depicts humans being as vehicles of power not its point of application.

Data showed that all the medical personnel in the study spoke more than one language. English language was spoken by all the medical personnel, but none of them spoke any foreign language such as French, Swahili and ChiShona[2]. Communication is an important aspect of access to health services the world over. In order for health services to be rendered effectively and efficiently health staff and patients need to understand each other. Where such communication does not exist or is poor, there is danger that at the very least patients may be given inadequate attention or prescribed wrong treatment. Since most Zimbabwean immigrants did not understand South African languages communication was a barrier that affected how they accessed health care. Health care personnel when spoken to in English responded in the languages that immigrants did not understand and if immigrants tried to speak in local languages they were ridiculed for speaking it terribly (Crush & Tawodzera 2011). The use of an interpreter or a common language that both immigrant patients and health care practitioners understand would solve the problem of communication, but some health care personnel were reluctant to speak in English which resulted in immigrants experiencing difficulties in accessing public health care.

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5.3.2 ATTITUDES OF PROVIDERS PUBLIC HEALTH CARE

Racial and cultural discrimination towards immigrants acted as a barrier in accessing health care services. Immigrants' experiences in hospital or health care clinics where discrimination by health

[2] French – The official language of France and its former colonies, Swahili - Language of East Africa spoken in more than six countries, ChiShona – Language spoken in eight of Zimbabwe's 10 provinces.

care professionals affected quality and efficiency of care were evident. Immigrants complained about the health care personnel that were very rude to the patients. The questionnaires showed that seventy seven percent of the medical personnel were rude to very rude. The interviews also confirmed these findings as they showed that medical personnel were very rude, P-5 referred to the nurse as her sister but the nurse said she was not her sister and that her sisters were at home, this exhibited how rude the medical personnel were to the immigrant patients. This non-acceptance of non-nationals by South Africans has been described by Landau et al (2005) as varying across South Africa's socio economic and ethnic spectrum. They argued that non-nationals leaving and or working in South Africa face discrimination at the hands of citizens, government officials, police and private organization contracted to manage their detention and deportation. Foucault' theory on power can also be used to explain the behaviour of the medical personnel and that of the immigrant patients. Foucault argues that oppressive measures are not just repression and censorship, but they are also productive, causing new behaviours to emerge. As immigrant continue to receive insults and experience arrogant attitudes from the medical personnel they developed new behaviours of resisting to the those bad attitudes by not entering in any form of arguments but just receive medical service which primarily would be what they would have gone to public health facility to receive and go home.

5.3.3 POLICY ISSUES

When the personnel manning the public health care centers in Cape Town were asked whether they were aware of the policy of National Department of health on immigrants and refugee patients they responded by thirty three per cent saying that they were aware and sixty seven per cent were not aware. For those thirty three per cent who said yes eighty six per cent said that it partially implemented and only fourteen per cent said it was fully implemented. The results showed that the public health care personnel were not aware of this policy that was formulated to safeguard the immigrants in accessing public health care, This could have aided to the barriers that immigrants experienced when they used public health care facilities because the people who were supposed to make sure that the rights of immigrants were reserved were not even aware of the existence of such rights, which is a sure cause of policies not well implemented and later on monitored and evaluated. In the first chapter I did mention that study was to look at the discrepancy between policy and practice and this study confirms that there was a disjuncture between policy and practice because the experiences of immigrant patients confirms how they were mistreated, deprived of their places in the queues, insulted, ignored or sent home without treatment in contrast to South Africa's constitution, international human rights, obligations and various professional codes of ethics governing the treatment of patients. Landau (2007) explains that identity documents cannot prevent discrimination or ensure social inclusion. Palitza (2008) alludes with Landau (2007) that Zimbabweans who had South African identity documents written born in Zimbabwe were denied access to some healthcare programmes because of them not being born in South Africa, this pointed out that South African medical personnel were unaware of the policy on public healthcare for

immigrants and refugees. Mupedziswa (2009) supports the same claims of immigrant population having difficulties in accessing public healthcare with or without proper documentation, he says while on paper the South African constitution is inclusive in terms of accessing social services it would appear forced migrants residing in that country have been short charged as they seem to be sinking into the quick sand of an inequitable access to social service. Foucault's theory on power unpacks this policy issue very well. Frontline staff are required to ask for certain documentation such as proof of residence and identification to create a patient profile, but if the patient cannot provide such documentation they still need to be assisted. Micro level power is exercised by frontline workers when they go by the book and refuse to assist the immigrant patients who might not have proof of residence or any form of identification. According to Foucault institutions use various types of enforcement power in terms of rules that are used to control each and every person who needs to be attended to should produce some form of identification and proof of residence. Foucault argues that this form of power is productive as it causes new behaviours to emerge. Immigrant patients will make a self-check and evaluate themselves before the go to public health care facilities by making sure they have what is needed to be rendered access to public health care. New behaviours can also be created by immigrants in the form of using alternative healthcare.

5.3.4 PREFERENTIAL TREATMENT

The immigrants who participated in both the interviews and questionnaires indicated that medical personnel offer preferential treatment to citizens over non-citizens. P-3 and P-19 indicated how they lost their places in the queue because they did not understand local languages. The environment at the public health care facilities favours citizens over non-citizens according to the participants. On the other hand the medical personnel indicated that ninety six percent do not offer preferential treatment to locals over non-locals and only four percent did. These mixed responses from immigrants and medical personnel can be elaborated using Foucault's theory on power. Foucault argues that power acts as source of social discipline and conformity which the institutions encourage and has become more of a norm in modern society. This means that medical institutions can enforce rules that in the end offer preferential treatment to locals over non-locals as they start by assisting those patients with South African identity documents this deprives anyone who does fall into that category. Immigrants according to this theory are still active participants of power relations as they conform to the requirements, they possess power to conform.

5.4 XENOPHOBIA

As Landau et al (2005) observed that although attitudes towards non-nationals especially black foreigners vary across socio economic and ethnic spectrum, there is strong evidence that non-nationals living or working in South Africa face discrimination at the hands of citizens, government officials and police and private organisations contracted to manage their detention and deportation. Harper & Raman

(2008) argue that these perceptions of locals towards immigrants contribute to the challenges that immigrants experience when they need to access public health care. Crush & Tawodzera (2011:1) defines medical xenophobia as the negative attitudes and practices of the health sector professionals and employees towards migrants and refugees on the job. The study confirms xenophobic tendencies in public health sector as participants indicated that they have been called derogatory names, deprived of their places in queues, sent home without being assisted and humiliated by medical personnel. Witholding of treatment from those who need it and any form of discrimination motivated by hostility to the patient based on their national origins is a form of xenophobia (Crush & Tawodzera, 2011) Foucault argues that power is diffuse rather than concentrated hence it is found in any kind of relationship and all the relations between subjects are power related and there is an interconnectedness between power and action. His theory offered an alternative explanation on the access to public health care by immigrants as a result of different forms of power that they yield and that of providers of public health care. When immigrants used public health care facilities they experienced difficulties in accessing services as they confronted mostly xenophobic locals manning the public health care centers who had power to withhold services and could influence the way in which these services are delivered. The vulnerability of being foreign placed the immigrants in a position of being ill- treated by locals because of their position of yielding lesser power but, Foucault's theory suggests that this power relation was productive as immigrants formed resistance to the medical personnel, by developing new behaviours which could use of alternative health care or endure the negative attitudes.

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5.4.1 TREATED WITH CONTEMPT

Zimbabwean immigrants when they used public health care system, were treated with contempt by the citizens manning the public health care facilities. The have been accused of bringing diseases to South Africa and the medical personnel treated them negatively as they felt it was not their problem and the immigrants should go back to their countries to be treated. P-1 indicated that even the general South African population also believed that immigrants bring diseases to South Africa from other countries.

5.4.2 SOCIAL ILLS

P-14, P-22 and P-28, in their interview sessions indicated that they had been blamed to be part of a large immigrant family that contributed to a lot of social ills such as prostitution, peddling of drugs and violent crimes. White Paper on International Migration (1999) also summarises the social ills caused by mostly illegal migrants which are that they compete for scarce resources with millions of South Africans, they compete for public services such as schools and medical care, they competed for insufficient job opportunities and trading opportunities, they are involved in criminal activities and they weaken the state institution by corrupting officials.

5.4.3 DEPLETION OF RESOURCES

Immigrants in the interview sessions indicated that they were accused for depleting and draining resources. P-7 indicated that at one institution, he overheard two citizens who said immigrants do come to South Africa to drain the resources meant for citizens. This accusation towards immigrants also happens in the developed countries. The presents of immigrants in South Africa is viewed with different perceptions however the study showed that immigrants both legal and illegal are mostly viewed as causing extra burden to the already overburdened public health care sector. Immigrants may have experiences in hospital or health care clinics where discrimination by health care professionals affect quality and efficiency of care, stereotypes of immigrants coming to United States to use up social services and take these services away from tax payers create a discriminatory stigma (Moss, 1996). Similar observations were made by Evans (2005) who says that concerns about the added burden of care and the draining of already depleted resources stemming from a general assumption that immigrants negatively affect the health and welfare of our society.

5.5 ALTERNATIVES TO PUBLIC HEALTH CARE

In both interviews and questionnaires Zimbabwean immigrants indicated that they use alternatives to health care as complementing the public health care or they use alternative health care as a form of acquiring treatment after they have been denied access to public health care. In the interviews P-29 indicated that when she get medication she takes it to the pastor to pray for the medicine so that she can heal faster. P-2 also indicated that two of his friends went for prayers from their church pastor after they were denied access to health care. P-17 knew of immigrants who were denied access to ART and they had to go to non-governmental organisations to access them. P-10 informed by colleagues who had to go to a traditional healer because they felt the disease could not be cured using the modern medication. P-4 indicated that when immigrants know that they do not have valid documentation they do not want to risk to go to public health care centres where Department of Home Affairs officials or police may be called in to arrest them so they prefer over the counter medication that they buy without being asked for nay documentation.

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Responses from the Zimbabwean immigrants' questionnaires shows that eighty percent of immigrants seek alternative healthcare other than public healthcare and thirteen percent do not. This indicates that there is a belief among immigrants that some other forms of healthcare can work in tandem with the public healthcare to provide them with alternative or complementary healthcare, considering also the barriers they face to access public healthcare, alternatives forms of healthcare were handy for most immigrants. Scheppers et al (2006) mentioned that the decision to use health services is stated to be an individual choice. These choices are mostly framed in the social context through cultural, social and family ties especially for ethnic minorities. They further explain that ethnic minorities first try to solve health problems on their own or in the circle of family members and friends. If one does not succeed

seeks the help of a great man in the community such as preachers or spiritual healers. Help of regular health services is often only called upon after an escalation of complains. Besides the choices taken by immigrant patients to seek alternative form of healthcare being influenced by cultural and social relations, Lamb & Smith (2007) brought another dimension of specific groups within refugee and immigrant population with particular health issues for whom health service provision is yet to be developed. In this situation immigrants will be left with no option but to try and seek for alternative forms of healthcare that remedy their situation. Perez-Escamilla et al (2011) outlined similar observation of immigrants who used alternative healthcare from the main stream healthcare when they explained how Mexican farm workers who live in the Californian counties in the United States and Mexican border areas preferred to cross the border and use Mexican primary care other than United States primary health because patients perceptions of healthcare quality were higher in patients who use Mexican primary health care than those that used United States primary healthcare. The choosing of alternative to health care shows that immigrants show resistance to the main stream doing of things and look for alternatives. As institutions according to Foucault exercise their power on immigrants, immigrants show a great deal of resistance to power exercised upon them by institutions by choosing alternatives to public health care as a way offering resistance.

5.6 CONLUSIONS OF THE STUDY

After conducting the study on the experiences of Zimbabwean immigrants on accessing public health care in Cape Town. The following conclusions were arrived at:

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Cross-border migrants in South Africa are routinely denied access to public health which they are entitled to despite the presents of protective legislation. Most Zimbabwean immigrants have been denied access to health care by health care workers who by law should not have denied them.

Most of those public health care workers manning the health care facilities display xenophobic tendencies, such that they are of the opinion that immigrants should not be entitled to anything. As they will end up competing for the scarce resources with the locals thereby draining the already depleted health care resources.

Most institutions do not follow directives that came from the National and Provincial governments. This was evident in 2007 when the National Department of health gave a directive that a South African identity document is not a pre-requisite for the access to ART, but some pubic clinics and hospitals still deny immigrants access to art on the basis of them not having a South African identity document and that the programme was for citizens only.

Policies on immigrants' access to public health care are not practiced by most public health care institutions. The policy states that no one should be denied access to health care with or without documentation. However many immigrants in the study indicated that they were denied access to health

care because they were sent home after they failed to produce either a form of identification document, proof of residence or make a payment. Some indicated that they produced their passport or asylum seeker permit, but they were not accepted by staff at public hospitals or public clinics registration points which was a huge breach of the laws of the land and policies of National Department of health.

The other conclusion that came out of this study was failure to uniformly apply policies by public institutions that provide public health care services. The institutions interpreted and practiced the policies differently from each other, what was acceptable at one institution was not acceptable at the other or vice versa. This failure to uniformly apply policy did also take place within one institution where what was acceptable to one immigrant of the same status was not acceptable to the other of the same status or vice versa or what was acceptable today was not acceptable the other day or vice versa, whereas the directives were the same and elaborate from the National Department of health. Failure to uniformly apply the policies resulted in some immigrants being denied access to use public health care facilities.

Xenophobic attitudes from some public health care workers also resulted in some Zimbabwean immigrant's failure to access public health care. The Western Cape Provincial Government, Department of Health's vision is 'Equal access to quality health care', but from the study this vision was not evident in most cases to the immigrant population. They were called derogatory names, deprived of their places in the queues, insulted and humiliated in front of the patients. Some have been communicated to in local languages which they do not understand, health workers in some instances were reported to have refused to communicate in English at all which contributed to barriers to access public health care.

5.7 RECOMMENDATIONS

Recommendations for this study have been put into sub-categories and what those sub-categories are expected to implement so that the barriers to public health care for immigrants may be reduced if not removed at all.

Governments-National, Provincial, and Local governments must first and foremost accept that there are problems of immigrants encountering difficulties in accessing public health care, and this affects their daily lives. The governments need to stamp authority and spell out that it is unconstitutional and against codes of ethics of healthcare personnel, to deny immigrants access to public health care. Governments should audit all the public health care institution on the levels of policy on migrants 'access to public health care as well as its implementation and effective mechanisms to ensure that institutional level policies are in line with national policies.

Public health care facilities- such as hospitals and clinics need to be informed that migration is a reality that South African have to accept and be able to deal with. They should ensure uniformity of application of policies such as use of a common language when assisting immigrant patients. Health workers at

these facilities should be made aware constantly of their responsibilities as they provide their services. Workshops on the issues of human rights for immigrants should always be done so that a constant reminder to the health workers about the immigrants will always be prevalent.

Training of public health care workers- The curriculum that is used to train new public health care workers should always include the rights of immigrants and be examinable at the end of the modules. The health workers should be taught about what is xenophobia and the effects of being xenophobic to immigrants. Their curriculum should also include modules that teach that the denial of health care to anyone let alone immigrants is a breach of South African law, health care policy, code of medical ethics and international conventions that protect immigrants ' rights.

Professional organisations and unions- are recommended to provide elaborate guidelines on how to treat immigrant patients in line with the laws of the country and their codes of ethics. Organisations such as Health Professional Council of South Africa, must be unwavering in the drive to ensure that laws of the land are not breached by their members. They should have a mandate to discipline members of their organisations who are found to breaching their policies. Unions such as Democratic Nurses Organisations of South Africa (DENOSA) and South African Democratic Nurses Union (SADNU) should also play a leading role in making sure that their members do abide to the codes of professional ethics and operate within the parameters of the laws of the country.

General population- civil society has also a bigger role to play to ensure that immigrants do not encounter difficulties in accessing health care. As they say 'charity begins at home' the general population must accept and demonstrate that are accommodative to immigrants because it is the general population that work in different government departments assisting immigrants and the attitudes they bring to work about immigrants makes a big difference on how they treat immigrants. Civil society such as groups, churches and non-governmental organization can also make a huge difference by making their members to be aware of South African law about immigrants and xenophobia. The groups can also assist by pulling out resources in terms of funding that can be used in programmes that teach the people to be accommodative to immigrants.

Media-Any form of media in South Africa does attract a following and media has the ability to 'make or break' anything that it will be talking about. In this case media is called upon to make a difference by disseminating information that is positive about immigrants so that a culture of trust and respect upon immigrants is created if there is need to address any ills related to immigrants, they can be better put across the in a way that citizens will appreciate that immigrants are also human and they can do wrong or do right just like anyone else.

Migrant help desk/hotline- immigrants help desks or hotline should be created. These will assist immigrants to report to authorities any unfair or unlawful encounters that they will have experienced. If immigrants do lodge a complaint it should be taken seriously and be addressed timely. The presence

of these facilities will also act as a deterrent to unfair an unlawful practices as health care workers will be afraid of being reported to if they do not follow legally outlined procedures.

Rewards and Punishment- these two principles need to be established in public health care so that, public health care workers who follow the law and policy on public health care for immigrants will be rewarded and this assist in the behaviour change for the others to be also recognised. Punishment should also be made clear to public health care officials that contravene official policy.

Collaboration with others- Department of Health alone will effect change but to a smaller extent collaboration with other departments such as, SAPS, Department of Home Affairs, Metro Police, will assist in addressing a range of interlinked needs and rights of immigrants.

5.8 LIMITATIONS OF THE STUDY

The main weakness to the study is that the sample was not large enough such that the findings that came out of the sample will be problematic to generalize to all the Zimbabwean immigrants as well as all the public health care facilities in Cape Town. The study was limited to only four public health care facilities with participants that were purposively sampled in so doing running a risk of creating a sample bias. A relatively larger sample with more probability sampling techniques would have minimized these challenges immensely.

5.9 STRENGTHS OF THE STUDY

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The structure of the research design provided a platform for the in depth insight of the experiences of Zimbabwean immigrants at the selected public health facilities in Cape Town. The in depth insight is very significant because of its ability to provide valuable information on the experiences of Zimbabwean immigrants in particular as well as other immigrants in general, as numbers of immigrants making way into South Africa is on the rise Landau (2007). The study also can be used to assist in policy formulation for the Department of Health and Department of Home Affairs. The objectivity of the study is also worth to mention as a strength as only people who were affected by the barriers of accessing public health care were selected to give their perceptions and experiences.

5.10 POSSIBILITIES OF FURTHER RESEARCH

Studies on the effects of denying anyone public health care in general and immigrants in particular in relation to the prevalence of HIV and AIDS .Further research can also be explored on areas of the positive attributes that immigrants contribute to the economic, social, religious and political circles of South Africa. This future research can explore ways of changing the general perceptions that South Africans have on immigrant population. Further studied may also explore how media can be an instrument that changes the perceptions of how ordinary South Africans view immigrants, as well as how best they can be treated within the principles of Ubuntu.

5.11 CONCLUSION

The main purpose of this study was to unearth the barriers to accessing public health care for Zimbabwean immigrants as a result of their experiences at selected public health care centres in Cape Town. The study indicated that Zimbabwean immigrant experienced barriers to access public health care in Cape Town such as barriers due to ineffective communication, attitudes from medical personnel, policies that were not practiced and xenophobia. These barriers contributed to the difficulties that Zimbabwe immigrants encountered and also to the use of alternatives to public health care as a result of these difficulties.

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APPENDIX A: APPROVAL TO CONDUCT RESEARCH AT KAYAMANDI, KHAYELITSHA, KRAAIFONTEIN COMMUNITY HEALTH CLINIC.

Verwysing
Reference
Isalathiso 19/18/RP104/2009

Navrae
Enquiries
Imibuzo Dr G Bernhardt

Telefoon
Telephone
Ifowuni 021 483 9292

Departement van Gesondheid
Department of Health
iSebe lezeMpilo

Mr Edgar Ngonidzashe Mafuwa
University of the Western Cape
Department of Anthropology and Sociology
Private Bag X17
Bellville
7535
Cape Town

Dear Mr Mafuwa

Experiences of Zimbabweans on the provision of health care at selected public health centres in Cape Town.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following members of staff to assist you with access to the facilities:

1. **Kayamandi Clinic:** Dr R Davids Tel: 021 887 0310
2. **Khayelitsha Site B CHC:** Ms Notsha funotshe@pgwc.gov.za Tel: 021 361 3816 2470/1/2/2
3. **Kraaifontein CHC:** Mrs Leana Steyn Lsteyn@pgwc.gov.za Tel: 021 987 0080

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted, nor service delivery compromised.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR J CUPIDO
DEPUTY-DIRECTOR GENERAL
DISTRICT HEALTH SERVICES AND PROGRAMMES
DATE: 14-12-2009

CC: DR G PEREZ — D: KHAYELITSHA & EASTERN SUB-STRUCTURE
DR L BITALO — D: NORTHERN & TYGERBERG SUB-STRUCTURE
DR L PHILLIPS — D: CAPE WINELANDS DISTRICT

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APPENDIX B: APPROVAL TO CONDUCT RESEARCH AT RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

Departement van Gesondheid

Department of Health

iSebe lezeMpilo

Verwysing: Reference: Isalathiso:	RESEARCH	Telefoon: Telephone: Ifowuni:	(021) 658 5383/5788
Navrae: Enquiries:	Dr. T. Blake	Fax:	(021) 658 5166
Datum: Date:	18 November 2009	Email:	Tblake@pgwc.gov.za

Mr. E. Mafuwa
16 Green Acre Terrace
Strand 7140

Dear Mr. Mafuwa

UNIVERSITY of the
WESTERN CAPE

Research Study: Experiences of Zimbabweans/Immigrant patients on the provision of health care at selected public health care centers in Cape Town

It is with pleasure that I inform you that approval has been granted to conduct the above-mentioned research and to hand out questionnaires in the Outpatients department at Red Cross War Memorial Children's Hospital.

Kind regards,

Dr. T. Blake
Senior Medical Superintendent

Red Cross War Memorial Children's Hospital
Klipfontein Road / Private Bag
RONDEBOSCH
7700 / 7701

Rooikruis Oorlogsgedenk Kinderhospitaal
Klipfonteinweg / Privaatsak
RONDEBOSCH
7700 / 7701

APPENDIX C: ETHICS APPROVAL BY SENATE RESEARCH COMMITTEE OF UNIVERSITY OF THE WESTERN CAPE.

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

8 October 2009

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by: Mr. E Mafuwa (Dept. of Anthropology/Sociology)

Research Project:	Experiences of Zimbabweans on the provision of health care at selected public health care centers in Cape Town, 1994 - 2009
Registration no:	09/8/6

Peter Syster
Manager: Research Development Office
University of the Western Cape

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A place of quality, a place to grow, from hope to action through knowledge

APPENDIX: D, QUESTIONNAIRE FOR ZIMBABWEAN IMMIGRANTS.

EXPERIENCES OF ZIMBAWEANS ON THE PROVISION OF HEALTH CARE AT SELECTED PUBLIC HEALTH CARE CENTERS IN CAPE TOWN.

Dear Participant

The main objective of this study is to understand the immigrants' problems they face when they seek medical services from the public sector in Cape Town. This questionnaire attempts to tap some information on the experiences of Zimbabwean immigrants as they seek medical services in Cape Towns' public clinics and public hospitals. Please respond as truthfully and as accurately as possible to all questions.

Rights of Participants

Participation in this study is voluntary, you may therefore not be forced to complete the questionnaire and you may at any moment decide to withdraw.

You will not be required to identify yourself. The information obtained during this study will not be utilised to identify participants and will not be used for any other purpose except academic.

By completing the attached questionnaire you are confirming that you understand your rights and that you give permission that your results may be used for investigation in this survey.

Thank you in advance.

Mazvita, Tatenda, Siyabonga khakulu, Enkosi khakulu, Baie dankie.

UNIVERSITY of the
WESTERN CAPE

Edgar N. Mafuwa

University of Western Cape

Department of Anthropology and Sociology

Private Bag X17

Bellville

Cape Town

South Africa

Mobile: 084 842 8596.

E-mail: enmafuwa@gmail.com

Please tick (✓) appropriate answer in box

1 Gender

Male		1
female		2

2 Age

18 to 25 years		1
26 to 33 years		2
34 to 41 years		3
42 to 49 years		4
50 and above		5

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3 Your present marital status

never married		1
married		2
divorced		3
widowed		4
separated		5

4 Education completed

O' level		1
A' level		2
Diploma		3
First Degree		4
Post Graduate Degree		5

Masters		6
Doctorate		7

5 Where do you reside in Cape Town?

---

6 When did you come to South Africa?

---

7 Why did you come to South Africa?

For better employment opportunities		1
For improved health care position		2
For better educational opportunities		3
Other(s) please specify		4

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8 What immigration status do you use when you are in South Africa

permanent resident		1
Student		2
asylum seeker		3
Refugee Status		4

9 What is your source of income in Cape Town?

Working		1
Selling items		2
Dependent on other people		3

Other

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

I have		1
I have not		2

11 How many times have you visited a hospital/ clinic?

Once		1
Twice		2
Thrice		3
Four times or more		4

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12 Have you been asked for any documentation that you use as your identity in South Africa at any clinic / hospital?

yes		1
No		2

13 Have you also been asked for any proof of residence so that you can be attended to at any clinic or hospital?

Yes		1
No		2

14 Have you been asked for any cash payment at any clinic or hospital?

Yes		1

No		2

15 If your answer to question 14 is yes, How much money were you asked to pay?

R1-R50		1
R51-R100		2
R101-R150		3
Above R150		4

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

Yes		1
No		2

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17 If your answer to on question 16 is No explain what transpired thereafter with your Case

_____

_____

_____

18 In your own words sum up your last experience at a clinic or hospital.

_____

_____

_____

_____

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

very fully aware		1
aware		2
partially aware		3
not aware at all		4

20 If your answer to question 19 is not, not aware at all, then is South Africa's policy on health care well implemented?

Fully implemented		1
Partially implemented		2
Not implemented at all		3

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

Yes		1
No		2

22 If your answer is No in Question 21, why do you think they are not aware?

_____

_____

23 If the answer is YES in question 21, do you think that they are practicing what the policy stipulates

very well		1
well		2
partially		3

not at all			4

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

Helpful		1
friendly		2
Rude		3
very rude		4

25 How would you describe the nurses/ doctors attitude towards you on your last visit?

Helpful		1
friendly		2
rude		3
very rude		4

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26 Have you ever been identified as an immigrant, or asked your country of origin by any member of the staff at any clinic or Hospital?

always		1
usually		2
at times		3
never		4

27 Have you ever had any language communication problems with both frontline and Or medical staff at any clinic / hospital?

Yes		1

No		2

28 If your answer to question no 27 is Yes, then how was this problem solved?

29 Have you ever been a victim of any foul language or xenophobia, name calling such as 'kwere-kwere' at any clinic or hospital?

Yes		1
No		2

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30 If your answer to question 29 is yes , please explain

31 Have you also been deprived of your place in a queue or sent back to the back because of your nationality?

Yes		1
No		2

32 If your answer is Yes in question 31 please, explain fully how this happened

33 **May you please explain the problems that are created when one is denied access to public health care.**

34 **Do you seek any alternative medical assistance to help remedy your medical problems?**

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always		1
usually		2
sometimes		3
never		4

35 **Are south African citizens accommodative to immigrants and refugees in general?**

Always		1
usually		2
sometimes		3
never accommodative		4

36 May you rate the efforts put by South African government to help immigrants and refugees in accessing public health care and other social services.

Very good		1
Good		2
Fair		3
Poor		4

37 Have you ever been deliberately ignored by any member of medical staff at any clinic or hospital such that you spent unnecessary time waiting to be attended whilst others are being attended to?

three times or more		1
Twice		2
Once		3
Never		4

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Thank you for your time and cooperation.

APPENDIX: E, QUESTIONNAIRE FOR MEDICAL PERSONNEL

EXPERIENCES OF ZIMBAWEANS ON THE PROVISION OF HEALTH CARE AT SELECTED PUBLIC HEALTH CARE CENTERS IN CAPE TOWN.

Dear Participant

The main objective of this study is to understand the immigrants' problems they face when they seek medical services from the public sector in Cape Town. This questionnaire attempts to tap some information on the experiences of Zimbabwean immigrants as they seek medical services in Cape Towns' public clinics and public hospitals. May you please respond as truthfully and as accurately as possible to all questions.

Rights of Participants

Participation in this study is voluntary, you may therefore not be forced to complete the questionnaire and you may at any moment decide to withdraw.

You will not be required to identify yourself. The information obtained during this study will not be utilised to identify participants and will not be used for any other purpose except academic.

By completing the attached questionnaire you are confirming that you understand your rights and that you give permission that your results may be used for investigation in this survey.

Thank you in advance.

Mazvita, Tatenda, Siyabonga khakulu, Enkosi khakulu, Baie dankie.

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Edgar N. Mafuwa

University of Western Cape

Department of Anthropology and Sociology

Private Bag X17

Bellville

Cape Town

South Africa

Mobile: 084 842 8596.

E-mail: enmafuwa@gmail.com

Please tick (✓) appropriate answer in box

1. Gender

Male		1
Female		2

2. Age

_____

3. Ethnicity

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African		1
Coloured		2
Indian		3
White		4
Other specify		5

4. Current marital status

Never married		1
Married		2
Divorced		3
widowed		4
separated		5

5. Highest education level

_____

6. Professional qualification(s) and the job that you do at this hospital/ clinic

Qualification,

Job _____

_____

7. Classification of area where you reside,

High density area		1
Medium density area		2
low density area		3

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8. How long have you been doing your current job?

0- 5 years		1
6-10 years		2
11-15years		3
16-20 years		4
21-25 years		5
Other- specify		6

9. What is your first language

Xhosa		1
English		2
Afrikaans		3
Other-- specify		4

10. How many languages can you speak?

one		1
two		2
three		3
four		4
five		5

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11. Do you speak any foreign languages such as Shona, Swahili or French?

yes		1
no		2

12. How do you communicate with immigrants who cannot speak English, Xhosa or Afrikaans?

_____

_____

_____

13. Do you have any interpreter sources at your clinic/ hospital?

Yes		1

No		2

14. If you have an interpreter services at your hospital/ clinic, what languages can they interpret?

15. How often do you see immigrant patients at this hospital/ clinic?

not so often		1
often		2
very often		3

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16. Have you ever turned any immigrant patient away from this hospital without treatment for any reason or another?

not at all		1
sometimes		2
every time		3

17. If you have sent an immigrant patient away without treatment, what are the main reasons which made you take such a decision?

18.when serving your patients , do you offer preferential services to local patients other the immigrant patients?

not at all		1
sometimes		2
all the time		3

19. Are you aware of the Department of Health policy on immigrants and refugees?

not aware at all		1
partially aware		2
fully aware		3

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20. If you are aware of the policy on health for immigrants and refugees? Do you think it is implemented at public health care centers?

not implemented at all		1
partially implemented		2
fully implemented		3

21. According to your center's statistics is the number of immigrant patients seeking ,medical attention on the increase or not?

It's decreasing		1
it's almost not changing		2
it's on the increase		3

22.Is your medical institution able to handle all the immigrant patients that visit your center for medical attention?

not able at all		1
averagely able		2
able all the time		3

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23. In your own opinion do you think it is a good thing for the government to provide immigrants with public health care?

not a good thing at all		1
a very good thing		2
undecided		3

24. Do you think that the volume of immigrant patients coming to your clinic / hospital have a Significant impact on the volume of work that you are supposed to do?

no impact at all		1
slight impact		2
very huge impact		3

25. Is the Department of Health able to supply this medical institution with all the things that you need to do your job well?

not at all		1
sometimes		2
all the time		3

THANK YOU FOR YOUR TIME AND CO-OPERATION

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APPENDIX: F, INTERVIEW GUIDE FOR SEMI STRUTURED INTERVIEWS.

PART: A BIOGRAPHICAL INFORMATION

- Gender
- Age
- Marital status
- Place of residence
- Type of accommodation
- Year of immigrating to South Africa
- Reasons for immigrating to South Africa
- Highest educational level
- Immigration status
- Source of income

PART: B POLICY/PRACTICES, EXPERIENCES AND PERCEPTIONS

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- Knowledge on Department of Health policies on immigrants
- Implementation of Department of Health policies
- Use of Public health care facilities
- How many times
- Where required to produce identification, proof of residency or cash payment for service to proceed
- Have you ever been denied treatment and sent back home
- How was attitude of medical staff towards you or other patients
- Did you encounter any communication problem
- Experience of any unfair treatment and preferential treatment offered to others
- Problems created when one is denied access to public health care
- South African in general are they accommodative to foreigners
- Rate efforts put by government to assist immigrant population to access social services
- Any questions that you have.

END

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