EXPERIENCES OF UNDOCUMENTED ZIMBABWEAN MIGRANTS ON ACCESSING HEALTHCARE SERVICES IN TSHWANE METRO, SOUTH AFRICA

by

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MINI-DISSERTATION

Submitted in partial fulfilment of the requirements for the degree of

MASTER OF PUBLIC HEALTH

in the

FACULTY OF HEALTH SCIENCES

(School of Health Care Sciences)

at the

UNIVERSITY OF LIMPOPO

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2020

DEDICATION

To my dear family and friends.

DECLARATION

I declare that **EXPERIENCES OF UNDOCUMENTED ZIMBABWEAN MIGRANTS ON ACCESSING HEALTHCARE SERVICES IN TSHWANE METRO, SOUTH AFRICA** (mini-dissertation) hereby submitted to the University of Limpopo, for the degree of **Master of Public Health** has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Zhuwau T (Dr) **18 November 2020**

ACKNOWLEDGEMENTS

I want to thank the following persons for their respective contributions to this mini-dissertation:

- A special thank you to my supervisor, Prof. L. Skaal, for her patient guidance, support and encouragement.
- My joint supervisor, Dr NJ Ramalivhana, for the guidance and support.
- Undocumented Zimbabwean migrants living in Tshwane Metro for their willingness to participate in this study.
- Tapiwa Chiwa and Sonia Mgiba for their assistance with the study.
- Family and friends for their love and support.

ABSTRACT

Background

Health status and access to adequate healthcare are vulnerabilities that undocumented migrants face in the receiving country. The purpose of the study was to explore the experiences of undocumented Zimbabwean migrants on accessing public healthcare services in the Tshwane Metro, South Africa.

Methods

A qualitative, descriptive and exploratory research was conducted to explore the experiences of undocumented Zimbabwean migrants on accessing public healthcare services in Tshwane Metro, South Africa. A group of undocumented Zimbabwean migrants (n=20) were purposively sampled. Data were analysed using a grounded approach.

Results

The study has highlighted the challenges undocumented Zimbabwean migrants living in the Tshwane Metro, South Africa face when trying to access public healthcare services. The study also highlighted the alternative health-seeking strategies the migrants were using to access health services. The findings revealed that there were tensions between public health workers and undocumented migrants. These tensions were contrary to international compacts as well as the policy provisions of the South African government.

Conclusion

A human rights paradigm needs to be central to any dialogue regarding migrants, legal or illegal, as their health status was invariably entwined with that of the citizens of South Africa.

KEY CONCEPTS

Migration, undocumented migrants, Zimbabwean, South Africa, healthcare seeking.

TABLE OF CONTENTS

LIST OF TABLES

DEFINITION OF TERMS

The following key concepts where used in the research to denote the meanings as described here:

Refugee: “A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.” (Department of Home Affairs, 2016:4)

Healthcare services: - The Farlex Medical Dictionary as quoted by Zihindula, Meyer-Weitz and Akintola (2015:9) defines healthcare services as “services provided to people or communities by agents of health services or professions for the purpose of promoting, maintaining, monitoring or restoring health.”

Human migration: - the movement of people from one place to another (Kok et al, 2006).

Illegal Zimbabwean migrant: - a citizen of Zimbabwe irregularly in South Africa. In other words, this term referred to a citizen of Zimbabwe who entered and stayed in South Africa through irregular means (Department of Home Affairs, 2014). In this study, illegal Zimbabwean migrants were Zimbabweans who did not have official documentation to stay in South Africa. In other words, they were undocumented migrants.

International migration: occurs when a person moves from one country to another country (Kok, et al, 2006).

Medical xenophobia: refers to the negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job (Crush and Tawodzera, 2011). The definition will be used as is in this study.

Migration: - The International Organisation for Migration (2015) defines migration as: *"*The movement of a person or a group of persons, either across an international border, or within a State."

Migrant: - a citizen of any other country who moves, either temporarily or permanently, from his original country to another (Canadian Refugees Council, [Sa]).

Undocumented Zimbabwean: - a citizen of Zimbabwe who did not have official permission to stay in South Africa, or had overstayed their visa or permit (Pursell, 2005).

Zimbabwean immigrant: - a citizen of Zimbabwe living permanently or temporarily in South Africa (Department of Home Affairs, 2014).

ACRONYMS

ANA	American Nursing Association
ART	Anti-retroviral therapy
CoRMSA	Consortium for Refugees and Migrants in South Africa
CoGTA	Cooperative Governance and Traditional Affairs
DHA	Department of Home Affairs
EU	European Union
GCIM	Global Commission on International Migration
GDP	Gross Domestic Product
ILO	International Labour Organisation
IOM	International Organisation on Migration
SADC	Southern Africa Development Community
SAMP	Southern Africa Migration Project
SAPHC	South Africa Primary Health Care
TB	Tuberculosis
TEBA	The Employment Bureau of Africa
TREC	Turfloop Research Ethics Committee

UN	United Nations
UNDOC	United Nations Office of Drugs and Crime
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission for Refugees
WB	World Bank
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 BACKGROUND

Population changes due to migration are increasingly receiving global attention (Martin, 2013). Socio-economic, political, environmental and other factors influence human migration (Martin, 2013; World Bank, 2011; Stats SA, 2011). The positive and negative impacts of international population movements (legal or illegal; forced or voluntary) at the countries of origin and destination, are increasingly felt not only by individuals, groups, countries, but indeed worldwide. Therefore, in today's world, information about international migrants tend to be biased, polarised and usually yield negative debates about migrants (Meny-Gibert and Chiumia, 2018; Mwiti, 2015; IOM, 2011; Bloch, 2010).

The determinants and consequences of international migration generate huge diverse interests and become the subject matter not only of several academic disciplines but government and organisational policies and programmes (IOM, 2011). Although some data are available nationally and internationally, they tend to be generally scanty, patchy and skewed (Santo Tomas, Summers and Clemens, 2009).

Such data shortcomings tend to negatively influence policies, debates, dialogues, as well as distort communication about migration. This contributes to anti-migrant sentiments which can likely lead to harmful stereotyping, discrimination and even xenophobia (IOM, 2011).

The topic is pertinent to South Africa given that South Africa is the destination of choice, other than Europe, for many refugees from sub-Saharan Africa. The Census of 2011 reports that they were about 2.2 million migrants in South Africa

(Stats SA, 2011). Anecdotal estimates put the figure at between three to five million African refugees in South Africa (Crush, 2001). However, Meny-Gibert and Chiumia (2018) dismiss the anecdotal estimates as a gross exaggeration of the number of migrants in South Africa.

Studies show that many of these migrants were undocumented (Wilkinson, 2015; Chiumia, 2013). Migrants face numerous constraints in the country of destination. The constraints range from hostility, inability to access essential services such as health, social welfare, employment and vital documents (Davis, Terlikbayeva, Terloyeva, Primbetova, and El-Bassel, 2017; IOM, 2016; Zihindula, Meyer-Weitz and Akintola, 2015).

Studies have shown that migrants also tend to have poor health outcomes compared to the host population (Crisp and Tawodzera, 2014; UNDP, 2013; Idemudia, Williams and Wyatt, 2013; Munyewende, Rispel, Harris and Chersich, 2011; Vearey, 2011b). The public health implications of a huge migrant population are significant. The movement of people inconsequentially provides conduits for the spread of diseases (Pursell, 2005).

Health is multi-dimensional. Health is not only a biological state but an indicator of the social and economic environment (Labonte and Schrecker, 2006). Migrants, more so undocumented ones, subsist in social, cultural, political and economic environments that compromise their health status (Wolff, Epiney, Lourenco, Costanza, Delieutraz-Marchand, Andreoli, Dubuisson, Gaspoz, and Irion, 2008; Derose, Escarce and Lurie, 2007; Marshall, Urrutia-Rojas, Soto-Mas and Coggin, 2005).

There is a long standing debate over the rights of migrants to access healthcare in countries of destination (Wachira, 2014; Crush and Tawodzera, 2011, Dwyer, 2004). The South African Primary Healthcare (SAPHC) system does not discriminate against migrants accessing public healthcare (Pursell, 2005). However, even in countries where the laws allow migrants to access healthcare

it has been found that medical xenophobia makes it impossible for migrants to access health services (Davis et al, 2017, Crush and Tawodzera, 2011; Landau, 2011). Healthcare workers have the power to withhold services and they certainly can influence the way in which these services are delivered.

Healthcare workers are influenced by their social environment (Southern Africa Migration Project [SAMP], 2006). A nationally representative survey conducted by the Southern Africa Migration Project (2006) found that 88% of South Africans surveyed had a negative impression of Zimbabweans and Somalians at 91% and Nigerians at 89% were more disliked.

Perceived xenophobic attitudes of healthcare workers are likely to negatively affect the healthcare seeking practices of undocumented migrants in South Africa (Kang'ethe and Duma, 2014; Crush and Tawodzera, 2011; Southern African Migration Project, 2006). Studies have shown that cultural, socio-economic and legal barriers further amplified the barriers to healthcare access among undocumented migrants (Wolff et al, 2008; Romero-Ortuño, 2004). Migrants tend to have poor health outcomes due to multiple stressors arising out of the migration process (Lindert, Schouler-Ocak, Heinz and Priebe, 2008; Ortega, Fang, Perez, Rizzo, Carter-Pokras, Wallace, and Gelberg, 2007). The lack of access to healthcare means that some migrants suffer from undetected health problems that put them at risk of severe ill-health if untreated (Ortega et al, 2007).

Commenting on the treatment of migrants within the European Union (EU) community, Lindert et al (2008) remark that limited access to healthcare and a system fraught with discriminatory practices inhibits some ethnic minorities from gaining access to healthcare and assurance of equal treatment once they enter the healthcare system. Derose et al (2007) make similar observations regarding immigrants in the United States of America. Anecdotal and published evidence suggests that undocumented Zimbabwean migrants in South Africa face similar

challenges as migrants elsewhere (Kang'ethe and Duma, 2014; Wachira, 2014; Munyewende et al, 2011; Crush and Tawodzera, 2011a).

However, there is limited peer reviewed studies on the experiences of undocumented Zimbabwean migrants on accessing healthcare services in Tshwane Metro, South Africa. This is not surprising as migrants tend to be in the limelight for all the wrong reasons in host countries (Gushulak and MacPherson, 2000). The difficult process of integrating undocumented migrants into mainstream South African society can have negative consequences for the health status of these migrants.

1.2 RESEARCH PROBLEM

The study focuses on undocumented Zimbabwean migrants in South Africa because they are recognised by the Department of Home Affairs as a critical migration issue under the Zimbabwe Special Dispensation (Department of Home Affairs, 2014). Zimbabweans constitute the largest migrant population in South Africa (Stats SA, 2011). The extent of the problem and the experiences of undocumented Zimbabwean migrants accessing public healthcare facilities is not fully known. This has implications on the health status of the migrants as well as for disease surveillance and control by South Africa as highly contagious diseases could be escaping scrutiny by the public health system.

It is, therefore, a matter of public health significance to explore the experiences of undocumented Zimbabwean migrants living in South Africa on accessing public health services. The absence of information on the health status of undocumented Zimbabwean migrants does not bode well for South Africa's public health care surveillance system and healthcare provision. The public health system needs to find ways to access this population. However, undocumented migrants are less likely to voluntarily come forward given their

immigration status and perceived xenophobic attitudes by public health officials (Munyewende et al, 2017, Dzimwasha, 2014).

1.3 PURPOSE OF THE STUDY

1.3.1 Research aim

The aim of the study is to explore the experiences of undocumented Zimbabwean migrants on accessing healthcare services in Tshwane Metro, South Africa.

1.3.2 Research objectives

The objectives of the study are:

- to describe the socio-demographic characteristics of the study participants.
- to explore and describe the experiences of undocumented Zimbabwean migrants on accessing public healthcare services in Tshwane Metro, South Africa.
- to describe the views of undocumented Zimbabwean on accessing public healthcare services in Tshwane Metro, South Africa.

1.4 RESEARCH QUESTION

The study seeks to answer the following research question:

- What are the experiences of undocumented Zimbabwean migrants on accessing public healthcare services in the Tshwane Metro, South Africa?

1.5 SIGNIFICANCE OF RESEARCH

The study is significant in as much as it contributes to the body of knowledge on migrants and their access to healthcare services in Tshwane Metro, South Africa. The public health policy makers can also benefit from the study insights into the issues pertaining to the delivery of public health services to migrant populations, especially undocumented ones as experienced by them. City of Tshwane metro will benefit from the study by getting to understand the experiences of migrants who are accessing healthcare services within the metro, thus, improving the quality of access to healthcare. Lastly, but not least, it is hoped that the migrants themselves will benefit from the study if it so happens that there is a positive reaction and response from public health and city officials to the study findings.

1.6 SUMMARY OF CHAPTERS

This chapter looked at the introduction and background of the study. It provided the research problem, study rationale, research question, aim and objectives of the study as the significance of the study.

- Chapter 2 reviews literature.
- Chapter 3 describes the study methodology.
- Chapter 4 presents data analysis and results.
- Chapter 5 provides study summary, recommendations, conclusions and limitations.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The chapter presents a review of literature on migration relevant to the study. The chapter looks at the global and regional nature of migration. This is followed by an exploration of migration within the Southern Africa region and in the South African context. Migration and access to healthcare by undocumented migrants in the global context is briefly explored. Migrants' access to healthcare services in South Africa is reviewed. Practices and attitudes towards migrants and related issues are also discussed.

2.2 DEFINING MIGRATION AND MIGRANTS

Human migration is the movement of people from one place to another. Migration happens for a variety of reasons. These can be economic, social, political or environmental. Push and pull factors drive human migration. "Migration is intraregional and domestic as well as short-term and seasonal." (Sanders and Maimbo, 2003:1). Human migration can be permanent, temporary, voluntary or forced. It can be international or internal. The International Organisation for Migration (IOM) (2011:62-63) defines migration as:

> *"*The movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants,

and persons moving for other purposes, including family reunification."

Permanent migration is when someone moves from one place to another and has no plans to return to their original home. Temporary migration is limited by time. This could be for seasonal employment. Forced migration involves the migrant having no choice but to move. Voluntary migration is the opposite of this (Weinstein and Pillai, 2001). International migration is when a person moves from one country to another country. International migrants are further classified as legal immigrants, illegal immigrants, and refugees. Legal immigrants are those who moved with the legal permission of the receiver nation, illegal immigrants are those who moved without legal permission, and refugees and asylum-seekers are those who crossed an international boundary to escape persecution (Weeks, 1999).

Internal migration refers to a change of residence within national boundaries, such as between states, provinces, cities, or municipalities. An internal migrant is someone who moves to a different administrative territory (Weinstein and Pillai, 2001). Migration can occur as result of push and pull factors. Push factors are those which force a person to move. This can include drought, famine, lack of jobs, over-population and civil war. Pull factors are those which encourage a person to move. These include a chance of a better job, better education and a better standard of living.

2.3 HUMAN MIGRATION AND CHANGING NATURE OF THE WORLD

Human migration is a global phenomenon. People move for a variety of reasons ranging from personal to forced choices. As noted above, people move for political, environmental, economic, religious, and familial reasons (Dwyer 2004). Modern-day migration is contentious and laced with hardening social attitudes towards migrants. This is despite migration being a characteristic of human

society and the one that opened the new world frontiers in the 19th century. The new world order has become increasingly anti-migration. In a paper prepared for the Global Commission on International Migration (GCIM) (Carballo and Mboup 2005).

Human society appears overwhelmed by the manner in which modern-day migration has unfolded. Human movement and the changing nature of the world and the speed at which they are occurring and their impact has raised either nativist or nationalistic and ethical debates on migration (Becerra, Androff, Ayon and Castillo, 2012; WHO, 2007; Dwyer 2004). Nativist debates argue the need to secure national borders, preserve national identity and resources for citizens whilst ethical debates argue the interconnectedness of humanity and the essence of human rights in dealing with migration (American Nursing Association, 2010a). However, the nativist argument appears to be holding sway over how to deal with the issue of global migration (Carballo and Mboup 2005).

The perception and acceptance of human migration becomes coloured and contentious once migration is categorised as legal and illegal (IOM, 2015). The latter group, as observed by Dwyer (2004:34) draws attention:

> "Illegal immigrants form a large and disputed group in many countries. Indeed, even the name is in dispute. People in this group are referred to as illegal immigrants, illegal aliens, irregular migrants, undocumented workers, or in French, as san papiers …"

As the number of migrants continue to grow there is a need to recognise that how they are categorised invariably determines their post-migration settlement and access to basic services such as shelter, food, health, security, etc. Literature paint a mosaic of approaches that are either progressive or retrogressive in dealing with migration and migrants. However, and predictably so, the predominant approaches in dealing with migrants, especially the

undocumented group have been retrogressive and in some cases laced with national security concerns (Zihindula et al, 2015; Hacker, Anies, Folb and Zallman, 2015; Woodward, Howard and Wolffers, 2013).

Provision of laws to control or curb migration brings the dimension of structural exclusion of migrants from mainstream society. Perhaps “the reluctance by many countries to ratify the Convention on the Rights of Migrants and the ongoing exclusion and discrimination of migrants in law suggests that many national and international policies have not yet been able to address the challenge of migration in a comprehensive fashion that takes into account the ethical and public health issues involved” (Carballo and Mboup, 2005:2).

The reluctance by nation states to have collective statutes on migration is disconcerting given that global migration is on the rise. Countries are left to deal with issues of migration as they deem appropriate given national considerations and mood.

2.4 INTERNATIONAL MIGRATION

We live in a world on the move. There is a dramatic and alarming rise in refugees, asylum-seekers and internally displaced people across the globe (IOM, 2015). International migration often has impact on public perceptions and on legislated migration policy (Kok, Gelderblom, Chouo and van Zyl, 2006).

According to the United Nations (UN), one billion people were on the move worldwide (UN, 2017). The UN further reports that of these people on the move, 258 million were international migrants (33% of the world population, increase from 155 million in 2000) The United Nations High Commission for Refugees (UNHCR) (2016) and the International Organisation on Migration (IOM) (2017) further state that 66 million of international migrants forcibly displaced worldwide due to war and conflict in 2016, highest level since World War II.

The rise in human migration has also seen a marked rise in populism and negative sentiments against migrants (Hatton and Williamson (2002) quoted in Kok et al, 2006). Countries often exaggerate the number of migrants living within their borders (Solomon and Jennings, 2017). Similar perceptual exaggerations of migrants are witnessed in South Africa (Wilkinson, 2015).

2.4.1 International migration corridors

There are four uniquely distinct international migration corridors. These are the South-South, South-North, North-North, and North-South migration corridors. “South is a developing country and North an industrialized country” (Martin 2013:2). South-South migration accounted for 36% of global migration, a total of 82.3 million migrants moved between South-South countries. South-North migration accounted for 35% of global migration, a total of 81.9 million people moved through this corridor. North-North accounted for 23%, 53.7 million people moved between industrialised countries. 13.7 million people or six percent of migrants moved from industrialised to developing countries, a North-South migration (Martin, 2013.).

The South-South and South-North migration impact Africa mostly as does the North-South to a lesser extent. According to the World Bank (2011:2) “Every country in Africa has been affected by international migration, in all its forms. Some people choose to migrate; others are forced to do so by natural disasters or conflict.” By 2011, 30 million Africans had migrated internationally – representing three percent of the continent’s population (World Bank, 2011).

However, the World Bank contends that this figure, which includes both voluntary migrants and international refugees, does not represent the true extent of migration from and within Africa. The World Bank (2011:2) states that “about two-thirds of migrants from Sub-Saharan Africa, particularly poor migrants, go to other countries in the region; the bulk of migrants remain within their sub-

regions." The push-pull factors or determinants of international migration are attributed to two inequalities and three revolutions (Martin, 2013). According to Martin (2013) the two inequalities are demographic inequality and economic inequality. Demographic inequality refers to the fact that the majority of global population, 5.9 billion, is in the developing world and the remaining 1.2 billion is in the industrialised world. Tied to the demographic inequality is the economic inequality which shows that the average annual per capita income is $3,300 and $39,000 in the developing and industrialised countries, respectively (Martin, 2013).

2.4.2 Types of international migration

The three major factors fuelling international migration are the communication; transportation; and human rights revolutions (Martin 2013). The rapid developments in communications, transportation and human rights have opened new frontiers in how mankind communicate, relate and perceive the world. The transformations have enabled sharing of information and human movement between continents, locations and places never witnessed before (IOM, 2015).

Kok et al (2006) contend that there are three major forms of international migration – labour mobility, asylum seekers and permanent migration. Kok et al (2006) further state that undocumented or illegal migrants are a subset of each of these categories.

Labour mobility

Labour mobility is the movement of people in search of work opportunities beyond their geographical or national boundaries. Kok et al (2006) contend that labour migration constitute, by far, the largest group of migrants in the world. It is supposed to be temporary, seasonal and short-term. However, this is not always the case. As observed by Ellerman (2006) in Kok et al (2006) there is nothing more permanent than 'temporary' migration. Many labour migrants do wish, at some point, to return to their countries of origin but the circumstances

they find themselves in the receiving countries militate against their quick return home (Kok et al, 2006). The dream of quickly amassing savings or wealth is often turns into a mirage and the labour migrants quickly fall into the trappings of illegal or undocumented migrants. In other words, temporary migration ends up being almost permanent migration (Kok et al, 2006).

Refugees/asylum seekers

Refugees and/or asylum seekers are people who are forced or coerced to move owing to circumstances that threaten their personal security or life. The South African Department of Home Affairs (DHA) (2016:4) defines a refugee as:

> "a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country."

There is always a sense of temporality to people who move as refugees or asylum seekers. The understanding is that they would return to their country of origin once the perceived threat to their lives is removed or addressed. However, the reality is that most refugees or asylum seekers do find it extremely difficult to voluntarily return to their countries of origin.

Permanent migrants

Permanent migrants are those who permanently migrate and have little or no desire to return to their country of origin. These are most likely to be highly skilled migrants whose skills are desired by the receiving country. Such migrants end up being granted permanent residence or naturalisation (Kok et al, 2006).

Undocumented migrants

Undocumented migrants are invariably referred to as irregular or illegal migrants. The irregular or illegal tag arises from non-compliance with the immigration laws or requirements of the receiving country. The DHA (2016:4) defines undocumented migrants as "… people who enter a country, usually in search of income-generating activities, without the necessary documents and permits; or who stay beyond the permitted period or acquire fraudulent documents."

2.5 MIGRATION WITHIN THE SOUTHERN AFRICA REGION

The IOM projects that there are more than three (3) million migrants within Southern Africa (IOM, 2016). This figure is from official sources and does not account for irregular/illegal migration as well as inaccuracies within official statistics. Migration within Southern Africa is both an historical and colonial artefact (IOM, 2016, Schierup 2015, Manik and Singh, 2013).

Historically, people in the Southern African region migrated as a result of tribal and nation-building wars such as the Zulu *Mfecane* wars of the 19th century (Phophiwa, 2009). The *Mfecane* wars saw Nguni speaking people migrating to modern day Malawi, Mozambique, Tanzania, Zambia and Zimbabwe.

The discovery of gold in the *Witwatersrand* belt as well as diamonds in the Transvaal region attracted migrant labourers, known as *Wenela*, from Southern Africa region into South Africa. The Federation of Rhodesia and Nyasaland also attracted migrant labourers from Northern Rhodesia (modern day Zambia), Nyasaland (modern day Malawi) and Portuguese East Africa (now Mozambique) into Rhodesia (present day Zimbabwe).

There are ebbs in migration trends within Southern Africa depending on the push and pull factors (Dinbabo and Nyasulu, [Sa]; UNHCR, 2012). Employment and

economic opportunities have been a significant pull factor in the region because of its mining and farming industries. On the other hand, political instability and lack of economic opportunities have been major push factors.

2.5.1 Migration into South Africa

South Africa is among the world's top five recipients of new asylum claims (IOM, 2016). South Africa is home to 68% of migrants within the Southern Africa region. Meny-Gibert and Chiumia (2016:1) note that the 2011 South Africa Census reported that:

> *"…*more than 75% of foreign-born (international) migrants living in South Africa came from the African continent. African migrants from the Southern Africa Development Community (SADC) countries contributed the vast majority of this, making up 68% of total international migrants. Immigrants from African countries outside of the SADC region made up just 7, 3% of all international migrants."

Table 2.1 gives a breakdown of the proportions of international immigrants as reported by the 2011 Census. More than three quarters of international immigrants were from Africa and the remaining quarter was from the rest of the world. This makes sub-Saharan Africa region the largest net contributor of migrants in South Africa.

Zimbabweans and Mozambicans constitute the largest numbers of Southern African immigrants in South Africa (IOM, 2016). Initial statistical reports from Statistics South Africa's (Stats SA) 2016 Community Survey show that Zimbabwe, Mozambique, Lesotho, Malawi, Swaziland and Namibia were among the top 10 migrant sending countries in 2016, together with the United Kingdom, Democratic Republic of Congo, Nigeria and India (Meny-Gibert and Chiumia

2016). However, Lesotho has the largest proportion of migrants in South Africa (Meny-Gibert and Chiumia 2016).

Table 2.1 International migrants in South Africa by origin

Region	%
Africa	75.3
Asia	4.7
Europe	8.2
Latin America and The Caribbean	0.3
North America	0.3
Oceania	0.2
Unspecified	11

Source: Africa Check, 2016

Historically migrants have streamed into South Africa as migrant labourers in the mining and farming industries (Meny-Gibert and Chiumia, 2017; IOM, 2016; Schierup, 2015; Manik and Singh, 2013). In recent times a new stream of migrants has streamed into South Africa as economic migrants and asylum seekers (Meny-Gibert and Chiumia 2017; Schierup, 2015; World Bank 2011).

The Department of Home Affairs (2016:8) recognises the historical and colonial roots of migration into South Africa:

> "In the colonial era the countries that now form the South African Development Community (SADC) were linked through a migrant labour system. Migration was probably the single most important factor tying together all of the various colonies and countries of the sub-continent into a single regional labour market during the twentieth century...")

South Africa entered into bilateral labour agreements with neighbouring countries - Botswana (1973), Lesotho (1973), Mozambique (1974) and Kingdom of Swaziland {now eSwatini} (1975) whereupon these countries would supply contract labour to the South African mining industry. The contract recruitment was done by The Employment Bureau of Africa (TEBA) which opened recruitment centres across several SADC countries (DHA, 2016).

In recent years the pull factors for migrants have been South Africa's progressive constitutional democracy and its stable political environment. The South African economy is a powerful magnet for both skilled and unskilled regional labour (Rasool, Botha and Bisschoff, 2012). The push factors have been political and ethnic instability and poor economic opportunities in most Sub-Saharan Africa (Martin, 2013; World Bank, 2011).

2.6 MIGRATION CONSTRAINTS AND CHALLENGES

Migrants, more so undocumented ones, subsist in social, political and economic environments that negatively affect their wellbeing (Hacker et al, 2015; Agudelo-Suarez, Gil-Gonzalez, Vives-Cases, Love, Wimpenny and Ronda-Perez, 2012). Migrants within the Southern Africa region face several challenges. IOM (2016:3) lists several challenges faced by migrants within Southern Africa:

- Diseases know no borders -such as malaria and other communicable diseases;

- Conditions surrounding the migration can make migrants vulnerable to ill-health

- Inequalities in accessing health services resulting negative outcomes for migrants and communities;

- Myths and misconceptions around migrants and health;
- Stigmatisation of migrants;
- Limited national and cross border monitoring systems;
- Limited knowledge and understanding of migration and health;
- Limited inter-sector and inter-country debate and partnership;
- Limited cross border referrals – resulting in to poor continuity of care and apparent increase in defaulters; and
- Limited harmonization of protocols – treatment, prevention, etc.

There are long standing debates over the rights of migrants to access healthcare in countries of destination (Hardy, Getrich, Quezada, Quay, Michalowski and Henley, 2012; Crush and Tawodzera, 2011; ANA, 2010a). The Farlex Medical Dictionary as quoted by Zihindula et al (2015:9) defines healthcare services as "services provided to people or communities by agents of health services or professions for the purpose of promoting, maintaining, monitoring or restoring health."

Even in countries where the law allows migrants to access healthcare it has been found that medical xenophobia makes it impossible for migrants to access health services (Hacker, Anies, Folb and Zallman, 2015; Dorn, Ceelen, Tang, Browne, Keijzer, Buster and Das, 2011; Dias, Severo and Barros, 2008). "Medical xenophobia refers to the negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job." (Crush and Tawodzera, 2011a).

2.6.1 Ethical dimensions of migration

The provision of healthcare services to undocumented migrants raises nationalist and humanist feelings (Vearey, 2018; Nicholas, Mfono, Corless, et al, 2016). Dwyer (2004:34) poses the question: “Do societies have an ethical responsibility to provide healthcare for them and to promote their health?”

Public health scholars should look into discrimination and bias within healthcare systems and access to healthcare for vulnerable groups such as undocumented migrants, refugees and asylum seekers. (Wild, 2015). The key question which needs to be explored is what constitute acceptable standards of healthcare for different migrant groups, and accessibility to such healthcare (Hacker et al, 2015). The conservative-traditionalist-nativist school of thought argues that what is perceived to be medical xenophobia is actually a policy position to conserve scarce resources for citizens (Kullgren, 2003). The conservative approach has been criticised from a human rights perspective (*Lancet* Commission, 2018; Crush and Tawodzera, 2011a, WHO, 2007 and from a public health science approach (Wild, 2015, WHO, 2007).

The humanist/public health ethics school argues that infectious diseases knows no national boundaries but thrive on human interactions, citing such diseases as tuberculosis (TB) and Acquired Immuno-Deficiency Syndrome (AIDS). Such infectious diseases, if left untreated, have significant health impact on the host population.

The South African government has aligned itself with the humanist school of thought in line with international human rights compacts and obligation (DHA, 2016). Both the Immigration and Refugees Acts do not bar documented migrants access to social services including healthcare (Pursell, 2005). The National Health Act 2004 articulates the provision of public healthcare to all people living in South Africa.

2.6.2 Social attitudes and access to healthcare services in South Africa

Migrants face several challenges and constraints in South Africa. The constraints range from hostility, trafficking to inability to access essential services such as health, social welfare, employment and vital documents (Mbembe, 2015; Kang'ethe and Wotshela, 2015; Kang'ethe and Duma, 2014; Mapokgole, 2014; Manik and Singh, 2013). The South African media reporting on migrants is largely negative and blames migrants for a variety of social and economic ills (Manik and Singh, 2013).

Crush and Tawodzera (2011a) report that there is a belief that South African public healthcare system is being overburdened by foreign nationals. In the SAMP (2006) survey, two-thirds of South Africans felt that foreign migrants "use up" resources and 49% felt that they bring diseases when they come into South Africa.

South Africans also feel that the right to access health services should depend on citizenship and legal status in the country. It is such attitudes that need to be explored in order to find out how they affect undocumented Zimbabwean migrants' health seeking behaviour and utilisation of public health services in South Africa.

Xenophobic attitudes and human trafficking in South Africa have exposed the ugly underbelly of international migration within the region. Solomon and Kosaka (2013:5) describe xenophobia as follows "Xenophobia, simply put, is the fear or hatred of foreigners or strangers; it is embodied in discriminatory attitudes and behaviour, and often culminates in violence, abuses of all types, and exhibitions of hatred." There have been many incidents of localised and targeted xenophobia in South Africa since the 1990s (Solomon and Kosaka, 2013; Umezerike and Asike, 2013).

The attacks on foreign nationals in 2008 and 2015 in South Africa drew international attention and subsequent condemnation. A number of foreign nationals, across major cities of South Africa, were attacked in coordinated waves of violence. The attacks were only targeted towards fellow Africans and under the guise that these foreign nationals were either criminals or job snatchers (Kang'the and Wotshela, 2015; Mbembe, 2015).

The fact that these attacks were only targeted towards fellow Africans by black South Africans led many commentators to label the attacks as Afrophobia or Negrophobia – a hatred of self that manifest itself in the otherness of fellow black Africans (Kang'ethe and Wotshela, 2015; Mwiti, 2015; Mbembe, 2015; Kang'ethe and Duma, 2014).

The xenophobic flare-ups and perceived ill-treatment seemingly force many migrants to stay away from the public health services and seek alternative care elsewhere (Mwiti, 2015; Kang'ethe and Duma, 2014). However, the extent of the problem and the experiences of undocumented migrants accessing public healthcare institutions are not fully known despite a few studies that have looked into the issue (Wachira, 2014; Munyewende et al, 2013; Idemudia et al, 2013).

Some South Africans feel that the right to access health services should depend on citizenship and legal status in the country (Manik and Singh, 2013; SAMP, 2006). The study, therefore, explored how attitudes like these affected undocumented Zimbabwean migrants' health seeking behaviour and utilisation of public health services in South Africa.

2.7 CONCLUSION

This chapter explored literature on migration. It looked at international and regional migration. Issues of migration and access to healthcare services were discussed. The chapter also explored the ethical question of provision of

healthcare services to undocumented migrants. The review of literature clearly indicated that there are limited public health studies on the health status and experiences of migrants on accessing health services in Southern Africa. Given that South Africa is the destination of choice for most migrants in southern Africa, it is critical that public policy acknowledges the policy gaps regarding public health approaches to undocumented migrants.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology and design. The study setting, population, sampling, ethical issues related to sampling, the sample are described. Finally, data collection and management processes are also described, starting from instrument design, collection, cleaning, entry, storage, and problems encountered are explained. The chapter also describes how validity and reliability of the data were assured and how issues concerning study bias were approached.

3.2 RESEARCH METHOD

The study used a qualitative (Seers, 2011; Burns and Grove, 2009), exploratory (Polit and Beck, 2008: 21), descriptive (Polit and Beck, 2008; Burns and Grove, 2009) approach to identify and explore the experiences of undocumented Zimbabwean migrants on accessing healthcare services in the Tshwane Metro, South Africa**.** As explained by Wyse (2011:1):

> "Qualitative research is primarily exploratory research. It is used to gain an understanding of underlying reasons, opinions, and motivations. It provides insights into the problem or helps to develop ideas or hypotheses for potential quantitative research."

Several mutually related variables giving insight into undocumented Zimbabwean migrants' health seeking behaviour (motivations, opinions, attitudes) were explored using in-depth interviews. The aim was to tease out the

nature of undocumented Zimbabwean migrants' healthcare choices and the consequences of such choices on their health and wellbeing. The 'why', 'what' and 'how' aspects of their health seeking choices and behaviour were important questions explored by the study (Varkevisser, Pathmanathan and Brownlee, 2003).

3.3 Research design

The research design was descriptive exploratory study design. It sought to explore the healthcare seeking behaviour of undocumented Zimbabwean migrants living in Tshwane Metro, South Africa. The study design chosen was deemed appropriate for the study because it was a non-intervention study that sought to explore and describe the healthcare experiences of undocumented Zimbabwean migrants in South Africa.

The study was descriptive and qualitative to allow a contextual perspective on the healthcare seeking practices of undocumented Zimbabwean migrants in the face of perceived hostility from South African nationals (Kang'ethe and Duma, 2014).

3.3.1 Study setting and sampling

The study was conducted in the City of Tshwane, Pretoria. The City of Tshwane is the third largest metro in the country. It contributes 27% of the Gross Domestic Product (GDP) of the Gauteng Province. It is also the seat of the country's capital city. The City of Tshwane Metropolitan Municipality covers an extensive municipal area that includes Central Pretoria, Centurion, Akasia and Soshanguve, as well as the surrounding areas of Mabopane, Atteridgeville, Garankuwa, Hammanskraal, Temba, Pienaarsrivier, Crocodile River, Winterveld and Mamelodi (Sokhela, 2007). This amounts to an area covering 6,297.83 km^2.

In 2017, the City of Tshwane's population size was projected to be 3 555 741 million people (CoGTA, 2020). "The biggest share of the population is concentrated in Regions 1 (Ga-Rankuwa, Soshanguve, Mabopane, Rosslyn) at 27%, followed by Region 6 (Eersterust, Lethabong, Mamelodi, Silverlakes, Garsfontein) and Region 3 (Pretoria CBD, Hercules, Danville, Atteridgeville, Laudium, Saulsville, Lotus) at 22% and 18%, respectively" (GoGTA, 2020:5)

Study population

Population in a research study has been defined as all possible participants who comply with the sampling criteria for inclusion in the research study (Burns and Grove 2005). The population for the study was undocumented Zimbabweans migrants living in the Tshwane Metro area. In other words, these were Zimbabwe nationals who were living in South Africa without regularizing their stay in accordance with the refuge and asylum laws of South Africa.

It is estimated that close to a million Zimbabweans are living in South Africa, legally and illegally. Most of the migrants reside in the metros in order to be closer to work opportunities. The undocumented Zimbabwean migrant population in Tshwane was identified through contacts among the Zimbabwean community living in Tshwane.

Sampling and sample size

The study used purposive sampling (Dawson, 2009) to select undocumented Zimbabwean male and female migrants in the Tshwane Metro. Purposive sampling was an appropriate methodology because the researcher chose participants who contributed to the information needs of the study and were willing to participate (Polit and Beck, 2009). Purposive sampling is an appropriated methodology when sampling participants with a specific type of knowledge or skill (Tongco, 2007).

The objective of using purposive sampling was to get in-depth insights on the healthcare seeking practices of undocumented Zimbabwean migrants using in-depth interviews. The researcher as a Zimbabwean had access to the Zimbabwean migrant community living in the Tshwane Metro. Entry into the undocumented Zimbabwean migrant community was gained through personal contacts in the Pretoria North East suburbs of Tshwane Metro.

The snowballing sampling technique (Burton, 2000) was used to recruit study participants. Snowballing is an appropriate research technique for studying marginalised communities (Burton, 2000). The researcher started with one participants already known to the researcher and who subsequently introduced the researcher to other potential participants who until data saturation was reached. Data saturation in qualitative research is a point where the researcher deems interviews are no longer generating new additional information (Polit and Becker, 2008).

According to Bernard (2002) there is no cap on how many participants should make up a purposive sample, as long as the needed information is obtained. A minimum of five informants was needed for the data to be reliable. Twenty undocumented Zimbabwean migrants were interviewed.

Inclusion criteria

The inclusion criteria for the study were undocumented Zimbabweans migrants who:

- Resided within the municipal jurisdiction of Tshwane Metro; and
- Understood and spoke English.

Exclusion criteria

The study excluded:

- All non-Zimbabwean migrants;
- All properly documented Zimbabweans (those with valid visas and permits to stay in South Africa);
- Undocumented Zimbabweans who did not speak English;
- Undocumented Zimbabweans living outside the municipal jurisdiction of the City of Tshwane; and
- Undocumented Zimbabweans who had not accessed public health facilities in the City of Tshwane.

3.3.2 Data collection

Data collection approach and method

The study used semi-structured in-depth interviews. An interview guide was used to collect data (Dawson, 2009). The interview guide was in English. The interview guide accorded flexibility in the data collection process (Varkevisser Pathmanathan and Brownlee, 2003). Given that this study was exploratory in design, the flexibility (allowance to explore issues at depth as opposed to a questionnaire) of the interview guide was useful in exploring sensitive issues such as the immigration status of the participants, their health status, and their experiences on accessing the South African public healthcare system. Socio-demographic data was collected from all participants.

Development and testing of the data collection instrument

The data collection instrument, the interview guide, was developed by the researcher based on literature on qualitative research instrument design. The interview guide covered migration history, healthcare experiences, and socio-demographic information. Input was sought from the researcher's supervisor as well as other postgraduate students on the design and content of the interview guide. Haque (1993), quoted in Burton (2000:336), four critical questions on designing research instruments guided the development of the interview guide:

- Would the question be understood the way I intend?
- How many different ways could the question be interpreted?
- Was the question likely to annoy, intimidate or offend?
- Was there a better way of asking the question?

Guided by these four important questions, the researcher pilot tested the interview guide on five Zimbabwean immigrants in order to test clarity, ambiguity, and comprehension of the questions the research was asking. Feedback from the pilot was used to fine tune the questions and develop the final version of the interview guide.

Characteristics of the data collection instrument

The interview guide was designed to generate a conversation on experiences of undocumented Zimbabwean migrants on seeking healthcare services. As the interviews were held face-to-face, it was important that the interview guide allow some flexibility in the manner and order in which questions were asked. Of primary importance was the need to develop an instrument that would allow participants to candidly express their sentiments and opinions regarding their experiences on seeking healthcare in the Tshwane Metro.

The interview guide focused on teasing out the experiences, opinions, feelings, knowledge and input of the participants. Hence it asked experiential questions such as: what are your experiences on accessing public health services in Tshwane Metro?

Data collection process

All the interviews were voice-recorded. Accompanying notes were taken by the researcher. The researcher also collected and collated observational notes, theoretical (assumptions) notes, methodological notes, and personal notes (Polit and Beck, 2008). Safety and privacy were primary concerns and guaranteed conducting the interviews in places agreed upon with the participant.

Ethical considerations related to data collection

Every research involving human subjects confronts ethical issues in terms of protecting participants' confidentiality. Similarly, all surveys meet ethical challenges in terms of informed consent (Presser, 1994). Therefore, as part of the requirements for undertaking research involving human subjects at the University of Limpopo, the study sought ethical clearance from the Turfloop Research Ethics Committee (TREC).

In addition, the study participants were informed about the purpose and procedure of the study and their consent was voluntarily sought. Expected duration of the participant's time, procedures to be followed were also explained before consenting. No names of the participants were collected. The interviews remained anonymous. Non identifying general socio-demographic data were collected.

All data collected remained accessible to the researcher and would remain under the custody of the University of Limpopo for the ethically prescribed period. Information concerning whom to contact for questions and concerns about the

research or any consequences thereof was also stated to the participants verbally and in the consent form.

3.3.3 Data analysis

Data were analysed guided by the principles of data analysis which recognise that:

- People differ in their experience and understanding of reality (there are many meanings)
- A social phenomenon can't be understood outside its own context. Reality is context-bound
- Qualitative research can be used to describe phenomenon or generate theory grounded on data
- Understanding human behaviour emerges slowly and non-linearly; and
- Exceptional cases may yield insights into a problem or new idea for further inquiry (Sunday, [Sa]).

Data was manually transcribed and coded from the recorded interviews by the researcher and an independent and competent transcriber using Tesch's analysis method for qualitative data (Creswell, 2009). Tesch (1990:141) suggests that interpretational analysis derives from at least four sources:

- The research question and sub-questions;
- The research instrument(s);

- Concepts or categories used by other authors in previous related studies; and

- The data themselves.

Stroh (2000:212) suggests a fifth source – “cultural/social context”.

Tesch’s analysis method was used to highlight emerging themes:

- Experiences of participants on public healthcare services in the Tshwane Metro;

- Opinions of participants on the healthcare services they receive in Tshwane Metro;

- Reasons for particular healthcare seeking choices; and

- Descriptions of certain procedures, practices or perceptions with which the researcher is not familiar (Varkevisser et al, 2003:249).

3.4 TRUSTWORTHINESS OF THE STUDY

Qualitative studies derive their trustworthiness from an honest and truthful presentation of the lived experiences of the study participants as opposed to quantitative studies that derive their validity and reliability through statistical testing (Frambach, van der Vleuten and Durning, 2013; Golafshani, 2003). The study ensured that the lived experiences and accounts of the undocumented Zimbabwean migrants living in Tshwane Metro were presented as narrated by the participants.

In other words, the narrative accounts of the undocumented Zimbabwean migrants were the primary focus of the study. Therefore, trustworthiness of the data was ensured through ethical, authentic, credible, dependable, confirming, transferable and triangulated research processes (Frambach et al, 2013; Polit and Beck, 2008).

Frambach et al (2013) summarises the quality criteria in qualitative research as below:

- credibility – the researcher ensured credibility by using triangulation where the researcher interviewed participants and recorded the interviews on a voice-recorder. The researcher also observed and took notes during the interviews. The researcher solicited participants' feedback on the data and interpretation thereof.

- transferability – the study ensured transferability by referencing similar studies on undocumented migrants and by providing readers with evidence that the research study's findings could be applicable to other contexts, situations, times, and populations (Lincoln and Guba,1985).

- dependability – the researcher ensured dependability by having an external audit of the transcripts and by consulting similar studies. The external audit, done by study supervisor, reviewed the data collection, data analysis and the results of the study and requested both transcripts and audio recordings of the interviews to determine their veracity.

- confirmability – the researcher ensured an audit trail as well as reflexivity on the data collection, data analysis and interpretation of participants' narratives. Greater care was taken not colour the narratives by giving them meaning outside that intended by the narrator. This involved double checking meanings and understanding with the participants.

- audit trail – data were stored in hard and soft copy to enable any data auditor or independent person to check it and reach a conclusion about the research.

3.5 RESEARCH BIAS

Several research biases were encountered given the study design. These are described below:

3.5.1 Selection bias

The research purposively sampled undocumented Zimbabwean migrants in the Tshwane Metro using the snowballing technique. This might have led to self-selection and friends selecting each other, limiting access to the experiences of other Zimbabwean migrants and variability of findings (Atkinson and Flint, 2001). It could well be that documented Zimbabwean migrants faced similar challenges when seeking public healthcare in the Tshwane Metro.

Participants were recruited from different locations in the North-East of Pretoria to ensure variability of information and experiences.

3.5.2 Researcher bias

Researchers bring personal and social bias to research. Their worldview colour the lenses through which they perceive the world and phenomena. Given the nature of the study, researcher bias was an ever present reality. Researcher bias presented itself in several ways.

Confirmation bias

To avoid confirmation bias, the researcher considered all the data obtained and analysed it with a clear and unbiased mind. The researcher continually re-evaluated the impressions and responses, and ensured that pre-existing assumptions were kept at bay.

Question-order bias

The question-order bias was addressed during the constructing of the interview guide and questions were revised and ordered suitably. During the interview process, participants were asked general questions first, before moving to specific questions.

In summary, researcher bias was minimised through bracketing. Bracketing is awareness of and getting rid of preconceived ideas in order to conduct the research with an open mind (Burns and Grove, 2009; Richards and Morse, 2007).

Leading questions and wording bias

The research kept questions simple and carefully avoided words that could introduce bias. The research also avoided leading questions that could prompt the participant to respond in favour of a particular assumption.

3.5.3 Participant bias

Participant bias was anticipated during the conduct of the study. Some of the anticipated biases were addressed in order to minimise their occurrence.

Social desirability bias

To minimise social desirability bias the research questions were phrased in a manner that allowed the participant to feel accepted no matter what the answer

was. The study also used indirect prompts that asked what a third party would do in a particular situation. This helped the participant to project his or her own feelings onto others and provide accurate, truthful, and more representative answers.

Acquiescence bias

The research used open-ended questions to prevent the participant from simply agreeing or disagreeing, and guided him or her to provide a truthful and honest answer.

Habituation bias

The research ensured that different questions were worded differently and that the questions were engaging throughout the interview in order to prevent participant from providing same answers to different questions.

3.6 ETHICAL CONSIDERATIONS

Ethical principles of beneficence, non-maleficence, autonomy and justice were addressed by the research (Richards and Morse, 2007). These ethical principles are affirmed in the National Health Act of 2004.

3.6.1 Seeking permission

- Ethical approval was obtained from the Turfloop Research Ethics Committee (TREC) before commencing with the study.

3.6.2 Rights of the participants

- Participants were informed verbally and in writing about the i) study purpose and time needed to participate, ii) their right to ask the researcher any questions related to the study, iii) their right to refuse to participate and to withdraw from the study at any time without negative consequences or any questions asked, iv) their right to refuse to answer any question; confidentiality was ensured by having one to one interviews in privacy.

3.6.3 Seeking consent

- Informed consent was obtained from each participant before they could participant in the research.

3.6.4 Harm

- The researcher took all feasible ethical and practical steps available to protect respondents from harm. This entailed seeking the necessary ethical clearances from the School of Health Sciences and the Turfloop Ethical Review Committees.

- The researcher fully disclosed the research objectives, the pros and cons of participants volunteering to be interviewed. Full disclosure entailed giving the participants detailed information about the study and its possible uses. It also entailed allowing participants to give informed consent and to exercise their right to withdraw from the study at any point in time.

- Minimal disruption to respondents' life was also ensured by avoiding scheduling interviews in ways that would inconvenience the participant.

No false hopes or expectations were raised by the researcher. No participant was bullied, coerced or forced into taking part (Dawson, 2009).

- The study was non-invasive. In cases where the participants became affected, psychological assistance was assured for the participants.

- Each participant was reminded not to answer any question that they did not feel comfortable about and of the fact that they could withdraw at any time.

- The researcher ensured his own personal safety by conducting interviews under a secure and controlled environment.

3.6.5 Confidentiality

- The researcher ensured that information supplied by respondents would not be disclosed directly to third parties. Information would only be accessed by the researcher and his supervisor (for supervision purposes only). The interview scripts would be kept according to the ethical requirements of the University of Limpopo and will be destroyed after the stipulated period. The researcher would not disclose names and locations of participants to any third parties.

3.6.6 Principle of beneficence

- The participants were informed of the perceived benefits of participating in the study. The results would be communicated to relevant structures of government and non-governmental organisations (NGOs) in order to facilitate public healthcare service delivery to all people living in South Africa, documented or not.

3.6.7 Data management

- Anonymity was assured by not using the participants' names on the documents and by keeping informed consent forms away from research documents;

- All the people who needed access to the research documents were made to sign a non-disclosure agreement (e.g. the transcriber);

- Study audiotapes and other confidential materials were kept in a locked safe place after the study; and

- Good and ethical research was ensured by having the researcher supervised during the study and the results of the research would be shared and communicated with the participants upon request.

3.7 CONCLUSION

The chapter looked at the research methodology and design. The study setting, population, sampling, ethical issues related to sampling, the sample were described. Finally, data collection and management processes were also described, starting from instrument design, collection, cleaning, entry, storage, and problems encountered are explained. The chapter also described how validity and reliability of the data were assured and how issues concerning study bias were approached.

CHAPTER FOUR

RESULTS, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The chapter presents study findings on the socio-demographic, migration and health-seeking behaviour of undocumented Zimbabwean migrants living in Tshwane Metro are described. The chapter will describe data management and analysis, the results, and give an overview of the results. The purpose of the study was to explore and document the experiences of undocumented Zimbabwean migrants on accessing healthcare services in Tshwane Metro, South Africa.

The primary research question was: “what are the experiences of undocumented Zimbabwean migrants on accessing public healthcare services in the Tshwane Metro, South Africa? “

Understanding of how undocumented migrants access healthcare services is an important public health concern in relation to human rights as well as policy development. True to the qualitative research paradigm, the researcher sought to understand the social phenomena of being an undocumented Zimbabwean migrant in South Africa and how it impacted their public healthcare access. The meanings, experiences and views of the undocumented migrants reflected the social structures and relationships that lie beneath migration in South Africa (Pope and Mays, 1995).

The objectives of the study were:

- to describe the socio-demographic characteristics of undocumented Zimbabwean migrants living in the Tshwane Metro, and

- to explore their experiences on accessing public healthcare services in Tshwane Metro, South Africa.

- to describe the views of undocumented Zimbabwean migrants regarding public healthcare services in Tshwane Metro, South Africa.

4.2 DATA MANAGEMENT AND ANALYSIS

Data were collected using in-depth interviews from 20 undocumented Zimbabweans living in the Tshwane Metro, South Africa. Participants were asked questions on their migration history and status, healthcare experiences and socio-demographic information. The primary question during the interviews was as follows:

"What are your experiences as an undocumented person on accessing healthcare services in the Tshwane Metro, South Africa".

The basic principle of qualitative research and data analysis is "to document adequately the richness and diversity of meanings people attribute to phenomena" (Holdaway, 2000:166). Since the research was exploring experiences of undocumented Zimbabwean migrants on accessing healthcare services, a grounded approach to data analysis was used (Strauss, 1987). Grounded approach is a system whereby the research themes emerge from the data.

A word of caution when interpreting qualitative data comes from Graneheim and Lundman (2004:106) who note that:

> "reality can be interpreted in various ways and the understanding is dependent on subjective interpretation…. Thus, our presumption is that a text always involves multiple

> meanings and there is always some degree of interpretation when approaching a text. This is an essential issue when discussing trustworthiness of findings in qualitative content analysis."

With Graneheim and Lundman (2004) advice in mind, the researcher adopted the following procedure:

- Listened to and read each interview through in full in order to get an overall feel for its whole content and what the concerns of the participant were;
- Circled words and phrases that seemed to recur in the text;
- Linking the circled words and phrases together through coding and categorizing the words and phrases; and
- Began the theory-building stage of the research as codes were being linked together as general themes emerged from the text.

Data collation, organization, analysis, and interpretation followed Tesch (1990) method of data analysis.

The coding process of the text were, therefore, guided by Tesch (1990) guidance on coding and involved:

- Getting a sense of the whole - reading all transcripts;
- Picking one document - going through it, asking what this is about? Writing thoughts in the margin;
- After several transcripts had been read making a list of topics;

- Clustering together similar topics;
- Going back to the data;
- Abbreviating the topics as codes and writing the codes next to the appropriate segments of the text;
- Finding the most descriptive wording for the topics and turning them into categories topics;
- Grouping topics that related to each other;
- Abbreviating each category;
- Alphabetising these categories/codes; and
- Assembling the data belonging to each category in one place and keeping track.

Text was read and re-read, notes were inserted alongside text and revisited several times as an eclectic, iterative, and reflexive process. The text was the unit of analysis – looking at both manifest and latent content (Graneheim and Lundman, 2004).

Wherever possible, participants were asked to clarify and validate the emerging data meanings. Themes and categories emerged as the analysis progressed. Initially, the themes were very broad. Overtime and in the process of engaging with text the broad themes were narrowed to a few specific themes and categories.

4.3 RESEARCH RESULTS

4.3.1 Socio-demographic characteristics

The age of the participants ranged from 26 to 41 years, with a mean age of 33.5 years. Seventeen participants had high school education. Three had tertiary education. Seven participants were married, nine were not married, three were on separation and one male did not specify his marital status.

Table 4.1 shows that participants were split evenly between female and male at 50% each. As for level of education, 85% of the participants had secondary/high school education and 15% had tertiary education. As for marital status of the participants, 45% were not married, 35% were married and 15% were on separation. The median duration for staying in South Africa was five-and-half (5.5) years and the median stay in Tshwane was three (3) years.

Table 4.1 Socio-demographic characteristics of the participants N=20

Demographic Characteristic		**Frequency**	**Percentage (%)**
Gender	Female	10	50.0
	Male	10	50.0
Education	Secondary (High)	17	85.0
	Tertiary	3	15.0
Marital status	Not Married	9	45.0
	Married	10	50.0
Area of residence	Pretoria Central	1	5.0
	Pretoria East	15	75.0
	Pretoria North	2	10.0
	Pretoria West	2	10.0
Median duration of stay in South Africa (years)		5.5	
Median duration of stay in Tshwane (years)		3	

4.3.2 Emerging themes and categories

Emerging these and categories from the content analysis of the narratives of undocumented Zimbabwean migrants are presented in Table 4.2. It should be pointed out that the delivery of healthcare within Tshwane District, of which Tshwane Metro Municipality falls within, is a shared mandate between the National Department of Health and City of Tshwane. The former manages most of the health facilities on the outskirts of the city and the latter manages the provision of health services within the Metro.

The participants may or may not have been aware of this shared mandate in the delivery of health services within the Metro. In this regard it assumed that participants were talking of their experiences with either City of Tshwane run facilities or National Department of Health run facilities. The Primary Health Care system is essentially the same.

Participants reported a variety of personal experiences with the public healthcare system in Tshwane Metro. They also reported a variety of health needs that made them seek municipal health services at various primary healthcare facilities in the Tshwane Metro. These ranged from tuberculosis (TB) treatment, ante-natal care, anti-retroviral treatment (ART), injuries, sexual reproductive health; lower and upper respiratory tract infections, mental health issues, non-communicable diseases and other health problems.

Some participants were already on chronic treatment in Zimbabwe before migrating to South Africa and faced challenges continuing with their chronic treatment once they arrived in South Africa as the two health systems are not linked and may be using different treatment protocols. Participants who were on TB, ART, hypertension and diabetes treatment talked of their challenges in securing similar treatment regimen in South Africa.

The emerging themes in relation to the primary research question were: a) state of hopelessness, b) de-humanising healthcare seeking experiences, and c) riding the system by the belly. Each theme had several sub-themes or categories. Sub-themes such as vulnerability, fear, harassment, constant movement, sexual exploitation, victimization, avoidance, name calling, unhappiness, embarrassment, communication barrier, document swapping, bribery, sharing of medication, sourcing of medication from home, and utilisation of private healthcare emerged.

Table 4.2 Emerging themes and categories

Theme	**Category**
4.3.2.1 State of hopelessness	Vulnerability Fear Harassment Insecurity Constant mobility Victimisation
4.3.2.2 Dehumanising healthcare seeking experiences	Terrible Shouting Time wasting Name calling Unhappiness Embarrassment Language barrier
4.3.2.3 Riding the system by the belly	Document swapping Sharing of medication Sourcing of treatment from home Bribery Private healthcare utilisation

The emergent themes are discussed below.

Theme 1: State of hopelessness

A key theme that emerged from the text was that of a state of hopelessness among undocumented Zimbabwean migrants. The migrants expressed hopelessness over their illegal migrant status and felt trapped by the situation in that they were unable to regularize their stay in South Africa and at the same time could not easily return back home to Zimbabwe. Several factors contributed to this feeling of entrapment and manifested themselves severally as vulnerability, fear, harassment, insecurity, need to be constantly moving, exploitation, victimisation, and extortion.

The migrants' irregular stay in South Africa exposed them to all forms ill-treatment from immigration officials, police, other public officials, and members of the public. They had no recourse to justice as they themselves were at conflict with South African law through their illegal stay in the country.

Participant 4 explained the feelings of resentment and unfriendliness she felt living in South Africa. The perceived hostility towards migrants by South Africans made it difficult for her to settle down.

> *"If you are an undocumented Zimbabwean life is very difficult in this area. Getting anything is very hard as the South Africans will not be too friendly to you. Generally speaking, South African public is not very friendly once they know that you are a Zimbabwean." (Participant 4)*

In the following quote, the participant described how she was constantly moving from one place to another as a survival tactic. Constant mobility seemed to be a permanent feature of the participant's stay in South Africa. She talked of how residents of the City of Johannesburg were more tolerant towards foreign nationals (majority of whom are undocumented) compared to residents of other cities of South Africa. She, however, noted how the police in the City of

Johannesburg exploited the vulnerability of undocumented migrants by constantly harassing and extorting them. She admitted to the hardships of life in Pretoria but her undocumented boyfriend insisted on staying in Pretoria because he felt the police in Pretoria did not harass them as much as police in Johannesburg.

> *"I have had to move places of residence several times. When I first arrived in South Africa I stayed in Johannesburg. Johannesburg is much better as South Africans in Johannesburg are now used to living with foreigners. Things are tough here in Pretoria. My boyfriend insists on us staying in Pretoria because there are not too many foreigners here and the police here do not harass you as much as the ones in Johannesburg." (Participant 1)*

> *"I am forced to change jobs and move from place to place as I am always being harassed due to my not having papers to stay here." Participant 17)*

Participant 17 reported the same experience of having to constantly move from place to place as Participant 1. It appeared the undocumented migrants' search for security and permanency by moving from one place to another simply increased their vulnerability.

Prostitution is rife among undocumented Zimbabwean women. Participant 2 talks about how some Zimbabwean women were resorting to prostitution.

> *"I have seen some Zimbabwean women resorting to prostitution just to get basic things because jobs are difficult to find if you are undocumented." (Participant 2)*

Extortion was a common feature in the lives of undocumented migrants. Participants 6, 8, 10 and 12 narrated the extortion and exploitation undocumented Zimbabwean migrants faced in South Africa.

> *"The area I am staying in they really don't care about your documentation status, as long as you can afford their rent, rates and charges you can find a place to stay. In the community some treat you well and others treat you badly." (Participant 8)*

> *"From the time I was in the Free State, I learned that South Africans value their languages a lot. I made it a point to learn their languages as best as I could so that my life in the community would be better. Even the police do not harass you a lot if you speak their language." (Participant 6)*

> *"My friend who took me in told me that if life was going to be better for me if I was able to speak the languages of South Africa. It is true. When I learned and started speaking isiZulu life got much better. I could find jobs and make friends without much difficulty." (Participant 10)*

> *"Being undocumented means you will never find a decent job besides you are always exploited." (Participant 12)*

The feelings of hopelessness among undocumented Zimbabweans living in South Africa are constant with similar findings (Zihindula et al, 2015; Idemudia et al, 2013).

Other studies of undocumented migrants in South Africa echo similar sentiments. Mujawamariya (2013) in a study of the lived experiences of Burundian and Rwandese refugees in South Africa found that there was a failure to integrate

into the South African community by the refugees due to perceived xenophobia. Katy and Jeff (2011) noted that migrants from the Horn and Great Lake Regions of Africa faced similar challenges of integration and discrimination in South Africa.

Studies elsewhere reported similar experiences by undocumented migrants. Undocumented economic migrants lived on the margins of society. They constantly reported fear, exploitation, victimization and vulnerability (Davis et. al., 2017; Villalonga-Olives, Kawachi and von Steinbüchel 2017; Hacker, et al, 2015).

A defining feature of the undocumented Zimbabweans was constant mobility. Participants reported moving from place to place in search of safety. The search of safety mostly turned out to be a mirage as the migrants quickly realised that the new place was not as safe as perceived initially. The constant state of mobility increased the migrants' vulnerability.

Peberdy and Dinat (2005) in their study of migration and domestic workers in Johannesburg remarked that migrant domestic workers experienced social isolation and separation which increased their vulnerability to exploitation and diseases such as HIV/AIDS. Misago, Gindrev, Duponchel, Landau and Polzer (2010a) made similar observations of vulnerability and mobility among migrants living in Alexandria township of Johannesburg.

Participants experienced or knew of other undocumented Zimbabwean migrants who had suffered sexual abuse and exploitation mostly at the hands of unscrupulous police. Sexual exploitation of vulnerable populations like displaced people, refugees, asylum seekers, migrant workers and undocumented persons is rife (Digidiki and Bhabha; 2018; Chynoweth, Freccero and Touquet, 2017; Keygnaert, Dialmy, Manço, Keygnaert., Vettenburg, Roelens. and Temmerman, 2014).

Sexual exploitation exposed the migrants to sexual transmitted diseases, unwanted pregnancies, trauma and social rejection. Keygnaert et al (2014) reported that sexual violence against sub-Saharan migrants trying to cross into Southern Europe through Morocco and Algeria was rife. They noted that the main perpetrators were Moroccan and Algerian officials as well as the leaders of gangs operating human smuggling and trafficking networks.

Besides facing sexual and physical violence many undocumented female migrants end up in prostitution. Participant 2 narrated how undocumented Zimbabwe female migrants were resorting to prostitution as a survival strategy. Undocumented female migrants and refugees are vulnerable to human trafficking networks, prostitution, and sexual violence (Brinlee, 2018; De Schrijver, Beken, Krahé and Keygnaert, 2018; Freedman, 2016).

The International Labour Organisation (ILO) estimated that 24.9 million men, women, and children were victims of human trafficking around the globe (ILO, 2017). The United Nations (UN) reports that 71% of trafficked persons are women and girls and more than 50% are sexually exploited (UNDOC, 2016). The phenomenon of undocumented Zimbabwean female migrants resorting to prostitution is in sync with global trends of vulnerable populations. Their social vulnerability made them easy targets to be preyed on by sexual predators and human traffickers.

Theme 2: Dehumanising healthcare seeking experiences

Another theme, and closely related to the theme of hopelessness, was that of dehumanizing healthcare seeking experiences. Participants reported about having unpleasant experiences when seeking healthcare from Tshwane health facilities. Descriptive experiential categories such as ‘terrible’, ‘avoidance’, ‘shouting’, ‘time wasting’, ‘name calling’, ‘turning up noses’, ‘embarrassment’, ‘unhappiness’ and ‘language barrier’ laced the health seeking accounts of the

participants. They depicted health seeking encounters that were traumatic, intimidating and unpleasant.

The following shows participants' responses when asked about their experiences accessing healthcare services in the Tshwane Metropole:

> *"It is next to impossible to be treated at public/government clinics without proper identifying documents." (Participant 4)*

Participant 4 was adamant that it was impossible to be treated at public/government hospitals without identifying documents. She had tried to use municipal health facilities a few times and each time she was asked to bring her identity documents (work permit, asylum permit, etc.). She narrated how she was turned away because she didn't have papers indicating her legal status in South Africa.

> *"At public government facilities the workers tend to ignore Zimbabweans." (Participant 2)*

> *"Maybe at public facilities they don't get paid well enough and they take it out on foreigners and also that they may not like Zimbabweans that much." (Participant 5)*

> *"I think they just don't like foreigners." (Participant 11).*

> *"At public healthcare facilities, the workers do not treat you that well once they know you are an undocumented Zimbabwean." (Participant 9)*

> *"Service is quite slow even for those with documents as long as you are Zimbabwean or foreigner." (Participant 14)*

> *I think they know or think it is against the law to help someone who does not have a permit in the first place. Maybe they simply do not like Zimbabweans altogether. Many people in this country attribute crime to Zimbabweans so this could be their payback." (14)*

Participants 2, 5, 9, 11 and 14 felt that healthcare workers in public facilities did not like Zimbabweans in general regardless of whether one was a legal or illegal. Their views were based on their experiences at public health facilities in Tshwane Metro.

Participant 5 felt that the attitude and behaviour of public healthcare workers came from their unhappiness with their working conditions. She postulated that healthcare workers were not paid enough and therefore frustrated with their work. The health workers ended taking it out their frustrations on their patients especially foreign patients.

Participant 14 felt it was against the law to give health services to an illegal immigrant. She felt that for one to access any social services they need to have a Home Affairs issued permit indicating their legal status in South Africa.

The perception that Zimbabweans were criminals also emerged from the narratives. Participant 14 felt that the healthcare workers had a negative attitude towards Zimbabweans because of the perception that Zimbabweans were criminals (Alfaro-Velcamp and Shaw, 2016; Mangezvo, 2015). The perception results in animosity and violence towards Zimbabweans.

Another participant narrated how she had been turned away by health workers in the City of Cape Town and Tshwane Metro. The health workers felt that she should not access treatment because she was an undocumented migrant and therefore in South Africa illegally:

"Yes, but I don't remember how many times. When I was in Cape Town mostly I self-medicated by buying medicines from private pharmacies. I did this because I tried many public government health facilities but they turned me away saying I had no permission to be in the country in the first place. It is also the same here in Tshwane without documents you do not get treated at these facilities." (Participant 3)

Some participants were of the view that going to public health institutions in Tshwane was a waste of time as they were most likely to be turned away or ignored:

"I have not gone that much to public health institutions because I know I will be wasting my time because the way they treated me that time I went was bad. If you say you have no documents, they look at you like you are not a human being and the end result after waiting a long time they send you away without treating you." (Participant 7)

"…I could see undocumented Zimbabweans getting turned away even those who required urgent medical attention. I could see undocumented Zimbabweans made to wait for long periods of time just for not having papers." (Participant 5)

The above quote echoed a common sentiment across the narratives of several participants. Participants felt the treatment they received at the hands of nurses, in particular, was dehumanising. The following quote captures this sentiment vividly:

"Some of the nurses look at you as if your dirty and smelling. They call you kwerekwere…" (Participant 13)

Kwerekwere is a derogatory term used by South Africans to describe foreigners (Kang'ethe and Wotshela, 2016, Matsinhe, 2011). However, the term has since evolved to exclusively refer to Zimbabwean migrants (Kang'ethe and Duma, 2014). The participants explained that the main perpetrators were nurses and administrative workers. Doctors appeared to be exonerated by the participants:

> *"Doctors are better than nurses ..." (Participant 17)*

However, it was not all gloom and doom at public healthcare facilities. There were good and bad days. As this participant remarked:

> *"The healthcare workers sometimes are friendly and help you with urgency and at times it is the opposite." (10)*

Theme 3: Riding the system by the belly

Faced by healthcare access challenges, the undocumented Zimbabwean migrants living in Tshwane Metro resorted to 'riding the healthcare system by the belly.' The participants reported several ways they were using in order to gain access to healthcare. Participants reported resorting to document swapping, sharing of medication, sourcing of medication from home, bribery, and using private healthcare.

The following quotes show some of the ways undocumented Zimbabwean migrants were using to access healthcare or treatment:

> *"… the second time I was staying here [Pretoria] and I was pregnant. I knew they would turn me away at public healthcare facilities so I took and went with my sister's documents. I used those for the duration of my pregnancy until I got my baby girl." (Participant 5)*

The above quote shows the extreme measure of document swapping that pregnant undocumented Zimbabwean migrants were resorting to. Participant 5 had to "borrow" her sister's documents in order to access ante-natal healthcare services. Undocumented Zimbabwean migrants were using social support networks to bypass barriers in accessing healthcare. Family, friends and other relations were a critical factor in accessing services for the undocumented migrants.

Participants 4 and 7, below, used the social network to access healthcare services. She first had to muster a local language. The ability to speak a local language allowed them to make South African friends. They then used the new social networks to access healthcare services:

> *"After two years I had made South African friends and I was speaking one of the local languages so I started borrowing passports to use at the public health institutions. … for me it has worked well because if you are confident and speak local languages, the healthcare workers are quick to agree that you are who you say are." (Participant 4)*

> *"At other times I go with my South African friends and I pretend to have left my ID book at home. At other times I can go with a friend and she pretends to be the one who is sick so that we get medicine." (Participant 7)*

Some participants were sourcing their chronic medication from Zimbabwe through a network of family members and transport operators. Participant 16 revealed how she and other undocumented Zimbabwean migrants were getting her chronic medication from Zimbabwe:

> *"Many people who are on chronic medication are surviving this way. The only challenge is when it is time to go for scheduled checkups." (Participant 16)*

Bribery of health officials was also reported. Undocumented Zimbabweans were paying bribes to personnel working at public health facilities in order to access health services:

> *"… sometimes you have to give them something to buy a drink [a small amount of money as a bribe]." (Participant 13)*

Utilisation of private healthcare was a popular option among undocumented Zimbabwean migrants interviewed. Several of them reported utilising private healthcare providers whenever they can afford it. Private healthcare providers were seen as more professional. Their service was also viewed as superior to that of public hospitals. Participants had this to say about private healthcare providers:

> *"When I have money I go to private healthcare providers as they mostly require your money. … Healthcare workers at private healthcare providers treat you well because they really don't care about your documents as long as you can afford what they charge." (Participant 19)*

> *"I went to a private healthcare facility. At private healthcare facilities the workers treat you much better because they want your money. Service at these facilities is fast as they use the policy 'first come first served.'" (Participant 3)*

Self-medication was another strategy used by the migrants. The participants said they self-medicated whenever they deem their ailment as not requiring professional help:

"That time it was only a little problem so I self-medicated by buying tablets from a pharmacy." (Participant 20)

It was clear, from the narratives, that the perceived healthcare access barriers were forcing undocumented Zimbabweans to resort to desperate measures in order to access public healthcare in the Tshwane Metro. The barriers were personal, social, cultural, political and economic. The interplay of these barriers made it difficult for undocumented Zimbabwean migrants to access healthcare services in the Tshwane Metro. As a result, the migrants were resorting to unorthodox measures in order to access healthcare services.

4.4 OVERVIEW OF RESEARCH FINDINGS

The narratives and experiences of undocumented Zimbabwean migrants when seeking healthcare in the Tshwane Metro are reflective of experiences of Zimbabwean and other migrants in South Africa (Mujawamariya, 2013; Katy and Jeff, 2011; Munyewende et al, 2011; Crush and Tawodzera, 2011a) and elsewhere in the region and internationally (The Lancet Commission, 2018; Zihindula et al, 2015; Martinez, Wu, Sandfort, Dodge, Carballo-Dieguez, Pinto, Rhodes, Moya and Baray, 2015).

The experiences of the undocumented Zimbabwean migrants were not unique. Biswas, Kristiansen, Krasnik and Norredam, (2011) made similar observations in their study on access to healthcare and alternative health-seeking strategies among undocumented migrants in Denmark. They found that undocumented migrants faced several barriers when accessing healthcare services.

The barriers forced undocumented migrants to seek alternative healthcare systems (Munyewende et al, 2011). Undocumented Zimbabweans migrants were using alternative healthcare seeking practices such as document

swapping, sharing of medication, sourcing of medication from home, using social networks, bribery, and using private healthcare.

This study found, similarly, that undocumented Zimbabwean migrants were resorting to alternative health-seeking strategies. Consistent with studies on undocumented migrants' access to social services, fear of authorities seemed to be the overriding barrier among participants (Hacker et al, 2015; Agudelo-Suárez,Gil-González, Vives-Cases, Love, Wimpenny, 2012; Ortega et al, 2007).

Fear of authorities, induced by their legal status made undocumented Zimbabwean migrants in Tshwane Metro apprehensive about utilising social services. This finding is contrary to Pophiwa (2009) assertion that legal status had no bearing on the utilisation of health services among Zimbabwean migrants in the Greater Johannesburg area.

Perhaps the position of the Department of Home Affairs regarding immigration management explains why undocumented Zimbabwean migrants are apprehensive of South African officials. There is no clear policy position and consensus in South Africa on how to deal with immigration (Department of Home Affairs, 2017).

The Department of Home Affairs called on other government departments to play a role and assist it in managing the complex issue of international migration without necessarily specifying the specific role each department had to play. Such policy implementation ambiguities are likely to play out in undesirable and problematic ways whereupon individuals or institutions take it upon themselves to define a desirable or undesirable international migrant.

A story in the Pretoria News newspaper of July 17, 2014 is instructive. A Somali refugee girl aged 12 years was denied access to life saving heart surgery and turned away by an academic hospital because she had no documentation or R250 000 deposit leading her brother to approach the North Gauteng High Court

for legal relief (Venter, 2014). Medical xenophobia has been reported in South Africa (Crush and Tawodzera, 2011a).

Seemingly, South African provincial health departments place blame on migrants for their inability to provide adequate health services to South African citizens. The South African Human Rights Commission (2016: [*Sa*]) has this to say:

> "… recent media reports have often focused on 'how an influx of health migrants' has placed a strain on the country's ability to deliver healthcare to its nationals. Some provincial health departments have lamented the strain on their limited resources due to the demand for services from migrants. These media reports and official pronouncements create conditions for refugees, asylum seekers and undocumented migrants to be denied access to healthcare services in public hospitals and clinics on the basis of their nationality or legal status."

The fear of authorities by undocumented Zimbabweans is therefore understandable and predicates their health-seeking behaviours. Although the perceived poor treatment by Tshwane health officials could be self-projected, it remains a cause of concern that undocumented migrants occasionally face barriers to accessing health services. This is in contradiction to international migration and human rights compacts (Abubakar, Aldridge; Devakumar; Orcutt et al, 2018). The fear of deportation back to Zimbabwe is a living reality for undocumented Zimbabwe migrants. This forces the migrants to be wary of government officials.

Undocumented Zimbabwean migrants were relying on newly established social networks to overcome access to healthcare barriers. However, these social networks were tenuous as they were influenced by one's ability to integrate into the South African community. The migrants quickly had to learn local languages and ways of life. The process of local integration is not easy as anti-foreigner

attitudes are real (Alfaro-Velcamp and Shaw, 2016; Chingwete, 2016; Kang'ethe and Wotshela, 2016).

4.5 CONCLUSION

This chapter presented the findings from the data analysis and supported with relevant literature. The results highlighted the experiences of undocumented Zimbabwean migrants living in Tshwane Metro when accessing healthcare services. The findings show that undocumented Zimbabwean migrants face challenges when accessing public health services in the Tshwane Metro. The study findings also highlighted the alternative health-seeking strategies the undocumented migrants were using to access healthcare.

The next chapter discusses the study summary, recommendations and conclusions drawn from the study findings.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS and CONCLUSION

5.1 INTRODUCTION

This chapter summarizes the study findings and possible implications in relation to the study question and purpose. It also seeks to offer recommendations on healthcare access by undocumented migrants living in South Africa. The chapter will argue for a humanistic and human rights-based rather than a populist approach to the emotive issue of undocumented migrants accessing social services. The limitations of the study and its findings are discussed.

The study sought to answer the following research question:

- What were the experiences of undocumented Zimbabwean migrants on accessing public healthcare services in the Tshwane Metro, South Africa?

5.2 RESEARCH DESIGN AND METHOD

The study used a qualitative, exploratory, descriptive (Burns and Grove, 2009; Polit and Beck, 2008) approach**.** The study therefore used qualitative research techniques which involved the identification and exploration of a number of often mutually related variables that gave insight into human behaviour (motivations, opinions, attitudes), in the nature and causes of certain problems and in the consequences of the problems for those affected.

The research design was a descriptive exploratory study design. The study sought to explore the experiences of undocumented Zimbabwean migrants when accessing healthcare services in Tshwane Metro, South Africa. The study design chosen was deemed appropriate for the study because it was a non-intervention

study that seeks to explore and describe the healthcare experiences of undocumented Zimbabwean migrants in South Africa. It was descriptive and qualitative to allow a contextual perspective on the healthcare seeking practices of undocumented Zimbabwean migrants in the face of perceived xenophobic attitudes from South Africans (Kang'ethe and Duma, 2014; Crush and Tawodzera, 2011a).

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The study found that undocumented Zimbabwean migrants living in the Tshwane Metro experienced barriers when accessing healthcare services. Barriers were at structural, individual and institutional levels. The interplay of the perceived and experienced barriers forced the undocumented migrants to seek alternative healthcare strategies. These findings are consistent with those of other authors who conducted similar research on migrants demonstrating that there are barriers to healthcare access for migrants in South Africa. However, Pophiwa (2009) is a notable exception.

5.3.1 Structural/societal level barriers

The social determinants of health are influenced by social, cultural, political, economic and policy provisions (Marshall et al, 2005). Aday (1989) quoted in Marshall et al, 2005:916-917) argues that "the main indicators of potential access to healthcare and health status are the characteristics of the population at risk, the characteristics of the healthcare system, and the characteristics of the environment." Undocumented Zimbabwean migrants living in the Tshwane Metro reported several structural barriers impeding them from accessing healthcare services in the Metro.

The barriers ranged from immigration requirements that excluded them from mainstream society on the basis of their legal status. Illegal migrants lived in

perpetual fear of arrest and deportation. Migrants literally played “cat and mouse” with law enforcement agencies and this forced them to live on the fringes of society and below the radar of authorities. The migrants also reported harassment by locals, physical, sexual and emotional exploitation. They could not access decent jobs.

The political and social environment in South Africa is such that there is no policy congruence as yet on international migration (Department of Home Affairs, 2017), especially undocumented migrants. The policy void meant that the issue of international migration and how to handle it remained unclear, murky and contentious. Undocumented migrants find themselves in limbo as they cannot access social services (Kang’ethe and Duma, 2014). To access the full range of social services one needs to be a citizen.

The international community recognizes the need for equity in healthcare access as a major determinant of global health outcomes (Abubakar et al, 2018; Edward, 2014; Biswas et al, 2012). Social injustice is the greatest push back on global efforts to combat disease and poor health outcomes. Restriction to healthcare access for undocumented migrants is universal (Martinez et al, 2015, Edward, 2014).

Migrants struggle to access healthcare services owing to their undocumented status, policy and legal provisions, enforcement, and cultural factors (Villanga-Olives et al, 2017; Hacker et al, 2015; Edward, 2014; Carballo and Mboup, 2005;). Social exclusion continues to be practiced by almost all countries despite international compacts aimed at improving global health and accessibility of health services (Agudelo-Suárez et al, 2012; Biswas et al, 2012; Romero-Ortuño, 2004; Solorio, Currier and Cunningham, 2004 et al, 2004). This is also the case with undocumented migrants in South Africa (Erasmus, 2015).

There is a well-documented anti-foreign sentiment in South Africa (Kang’ethe and Wotshela, 2016; Chingwete, 2016). The anti-foreign attitude is fueled by

populist rhetoric that foreign nationals are taking away jobs and overwhelming social services (Maistry, 2015). Even though there is no empirical evidence to back up such sentiments, they tend to gather support in an economy which is facing job creation and social services provision challenges (Kang'ethe and Duma, 2014). On the contrary, "there is some evidence that IMs use public healthcare facilities significantly less than the rest of the population" (Romero-Ortuño, 2004:263). Ortega et al (2007:2359) make a similar claim in their study of healthcare access, use of services, and experiences among undocumented Mexicans and other Latinos in the USA.

5.3.2 Institutional level barriers

The undocumented Zimbabwe migrants who participated in the study also faced healthcare access barriers at the institutional level. Healthcare workers at public health facilities in the Tshwane Metro were taking arbitrary decisions to deny or limit healthcare to undocumented Zimbabwe migrants. Other studies reported similar findings (Crush and Tawaodzera, 2011a, Munyewende et al, 2011).

The participants cited healthcare workers' attitudes towards them as a major obstacle. The participants reported that they were ignored, called derogatory names, insulted and humiliated by healthcare workers. The migrants reported that the hostility of healthcare workers was most likely influenced by social perceptions that Zimbabwean migrants were committing crimes.

The health system is a critical element of health delivery. The institutional barriers faced by the migrants are symptoms of the South African primary healthcare system. The human resources are stretched, morale is low and there is general unhappiness with working conditions (Coovadia, Jewkes, Barron, Sanders and McIntyre, 2009). These institutional challenges were common throughout the Southern African region and not unique to South Africa (Zihindula et al, 2015).

The systemic challenges of under-resourced health facilities imply that the health workers are overworked, edgy and impatient. The participants repeatedly mentioned their dissatisfaction with the quality of service at the Tshwane Metro's public healthcare facilities. They had general mistrust of the public healthcare system.

There are no specific provisions for migrants within the South African public healthcare system. It is a one size fits all approach. There are no dedicated programmes within the public health system to address migrants' health needs. Migrants, therefore, tend to lack adequate and correct information about health services offered by Tshwane Metro. This leads to mistrust and misconception of the public healthcare system.

5.3.3 Individual level barriers

The migrants reported several individual level barriers to accessing healthcare services. Similar to global findings, the individual obstacles were lack of social support networks and sense of isolation (Agudelo-Suárez et al, 2012; Rodriguez, Bustamante and Ang, 2009; Solorio et al, 2004). The migrants reported a pervading sense of fear of authorities and acute mistrust (Biswas et al. 2011). They also reported experiencing communication challenges. Solorio et al (2004) reported that language was a significant communication barrier for Mexican migrants in the USA.

Individual isolation increased the Zimbabwean migrants' sense of apprehension and vulnerability. Avoidance of public health facilities and seeking alternative healthcare was commonly reported by the migrants.

5.4.3 Alternative health-seeking strategies

In an effort to deal with their vulnerabilities and survival, the undocumented migrants sought alternative healthcare strategies and social networks. The migrants developed local social networks which then assisted them to bypass

the public health system identity checks by using someone else's identity document or permit. They preferred to use private health providers whenever they could afford it. In some cases, they paid bribes to staff at the public health facilities. Some resorted to self-medication and other to sourcing their medication from Zimbabwe.

Fear, justified or unjustified, led the migrants to seek alternative healthcare strategies some of which were most likely to be harmful to them (Marshall et al., 2005). Self-medication was done without a proper medical diagnosis by a health practitioner. The practice of sourcing treatment from back in Zimbabwe was a dangerous practice as this was being done without the requisite medical checkups.

Biswas et al (2011) found similar practices among undocumented South Asian migrants in Denmark and elsewhere. Biswas et al (2011:9), quoting a study in Germany that observed "undocumented migrants [in Germany] had a wider use of non-prescription medications and illegally obtained medications which may be of public concern as unregulated use of medications such as antibiotics can increase resistant strains."

Similarly, undocumented Zimbabwean migrants may be putting their health at risk through self-medication and home-sourcing of medication. The implications of such practices for South African public health could be dire as the health of the host population is inextricably linked with that of migrants (McDonald and Kennedy, 2004).

5.4 CONCLUSIONS

This study found that there are obstacles confronting undocumented migrants on accessing health services in South Africa. The barriers were at a societal, organizational and individual level. Fear was pervasive among the

undocumented migrants and exacerbating their level of anxiety and vulnerability. The study findings highlighted abuse and harassment of undocumented Zimbabweans by the public health system leading the migrants to seek potentially harmful alternative healthcare strategies.

Finally, there appears to be policy gaps in the provision of social services to migrants in South Africa. There are tensions between health, migration and policy domains (Torres-Cantero, et al. 2007). The policy contradictions and ambiguities create institutional dissonance and confusion when providing healthcare services to undocumented migrants. The public health consequences of having an under-serviced migrant population are significant and far-reaching as the health of the host population is invariably affected by that of the undocumented migrants leaving below the radar of society.

5.5 RECOMMENDATIONS

South Africa is a signatory to many global compacts of human rights, health, refugees, migration, vulnerable populations, undocumented persons, etc. The proclamation of universality in the Bill of Rights has put South Africa at the centre of global efforts to recognise and protect progressive human rights. Undocumented migrants are a vulnerable population and require protection.

However, it seems, like in most other countries these civil and political rights "… were anchored to *citizenship* …" (Romero-Ortuño, 2004:249). There is a persuasive ethical and human rights argument that the political and civil rights must be protective of all, citizen and non-citizen (Smith and Upshur, 2015). Health is a shared global responsibility and a basic human right.

In light of the findings of the study, the following recommendations are made:

- Policy ambiguities around undocumented migrants and their access to social services be addressed to remove the structural barriers obstructing migrants from healthcare services. There is both a humanitarian and utilitarian justification to the provision of healthcare to migrants as their wellbeing affects the wellbeing of the host population;

- Social integration of migrants should be proactively promoted through visible public integration programmes and campaigns. We live in a global community and global citizenship is real. The “us” and “them” is a false dichotomy in the context of global human networks;

- Public institutions and officials should play a proactive role in safeguarding the health of South Africans and migrants by creating engagement platforms free of stigma, fear, harassment and discrimination.

There is no evidence that undocumented migrants are a drain on the resources of South Africa. Both economic and non-migrants are self-sustaining. We need to acknowledge the tensions over access to job opportunities in an environment where more than 25% of the indigenous population is unemployed.

However, more studies need to be contacted to better understand the economic and social contribution of migrants to local economies. There is need for a balanced discussion of normative rights, needs, duties, responsibilities and organised efforts of society in dealing with the issue of migration.

5.6 CONTRIBUTIONS OF THE STUDY

This study contributes to the body of knowledge on migration, specifically international migration. It also contributes towards the public health knowledge body by highlighting the public health needs of undocumented migrants in South Africa and perhaps elsewhere. The study contributes towards public policy studies by highlighting the policy shortfalls in dealing with migration. It also

contributes towards social studies by highlighting societal factors that affect migrants' health and wellbeing.

5.7 LIMITATIONS OF THE STUDY

The study findings and implications thereof are based on interviews with a small heterogeneous group of undocumented Zimbabwean migrants living in Tshwane Metro. The participants and their experiences do not represent the entire community of undocumented Zimbabwean migrants living in Tshwane or elsewhere in South Africa. The findings are "are clearly influenced by individual and contextual characteristics related to age, gender, ethnicity, undocumented migrant sub-category…" (Biswas et al, 2011:8).

The clandestine nature of undocumented migrants makes it challenging to study them and validate issues (Biswas et al, 2011:8). The potential for social desirability is ever present in studies of this nature. One cannot, therefore, rule out the fact that participants projected themselves in a manner that enhanced their personal circumstances. However, every effort was made to encourage the participants to speak freely and reassure them of the anonymity of the interviews.

The inclusion and exclusion criteria introduced possible bias into the study in that it only interviewed undocumented migrants conversant with the English language. This excluded all migrants who could not speak or understand English. The rationale was that migrants would need to be able to speak English when they interact with health workers given their inability to fluently express themselves in local languages.

The study did not interview local healthcare worker to hear their side of the story. It could be that they have a different story to tell from that of the participants in the study. There is need to interview healthcare workers in the Tshwane Metro and find out their views on migrants accessing healthcare services.

5. 8 CONCLUDING REMARKS

The study, though limited in scope, provided useful insights into the healthcare experiences of undocumented Zimbabwean migrants living in the Tshwane Metro. It also provided insights into the alternative health-seeking strategies migrants use in the face of challenges in accessing formal public healthcare. The study findings revealed that undocumented migrants are suspicious of authorities and apprehensive. This increased their vulnerability and impeded their ability to access services. Therefore, their inability to access health services could be a self-projected limitation.

It also emerged that the policy environment needs to be revisited to make it more responsive towards the needs of migrants, especially the undocumented sub-category. The current policy uncertainty was playing into the hands of populist rhetoric about foreign nationals resulting in the abuse of the human rights of migrants.

It should be emphasized that migration is a global phenomenon. Given its strong democratic and economic status within sub-Saharan Africa, South will continue to be an economic magnet. There is need, therefore, to have proactive and progressive strategies and policies to deal with international migration in a manner that benefits South Africa and the continent. South Africa should give leadership in this sphere as it is doing in the human rights, democracy, political and economic spheres.

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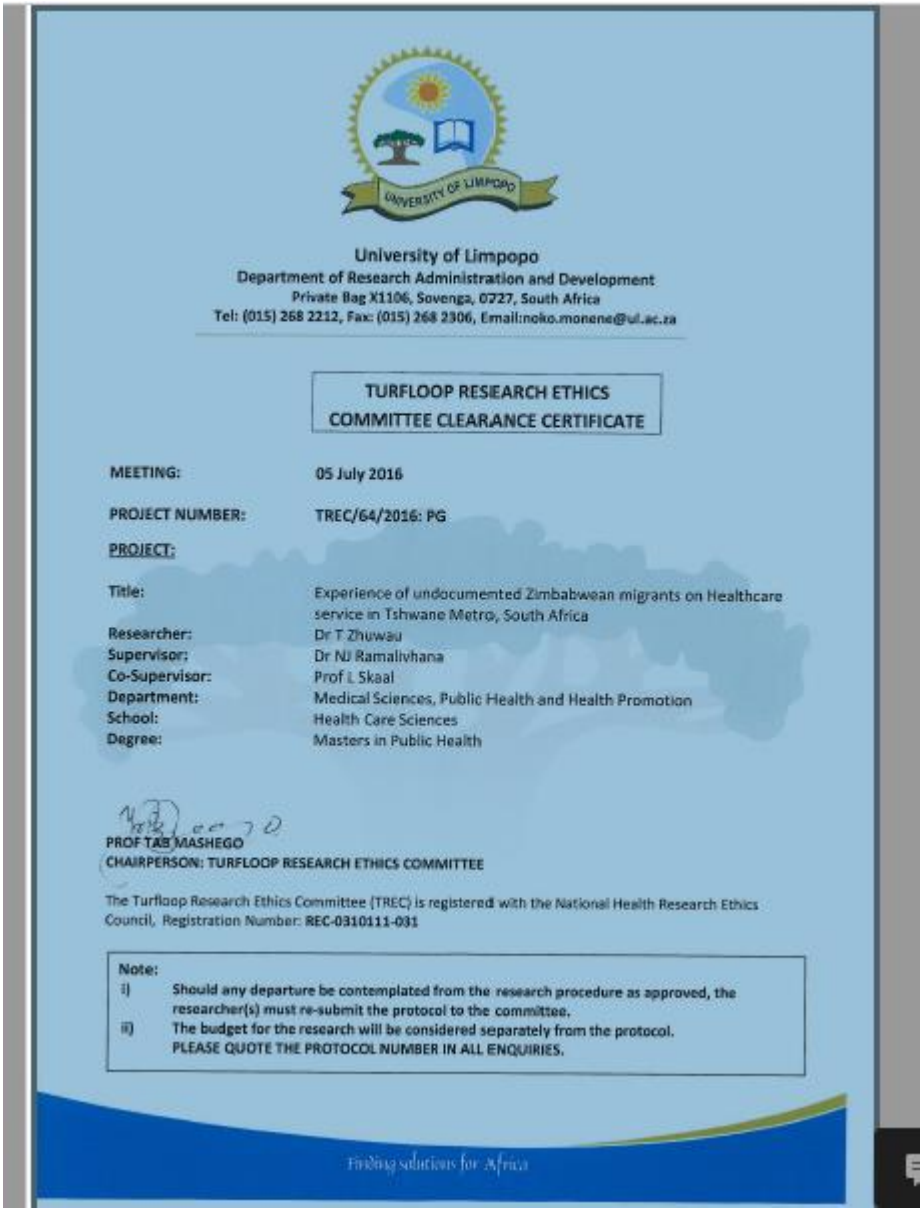
APPENDICES

7.1 **Appendix A:** Approval from the university



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TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING:	05 July 2016
PROJECT NUMBER:	TREC/64/2016: PG
PROJECT:	
Title:	Experience of undocumented Zimbabwean migrants on Healthcare service in Tshwane Metro, South Africa
Researcher:	Dr T Zhuwau
Supervisor:	Dr NJ Ramalivhana
Co-Supervisor:	Prof L Skaal
Department:	Medical Sciences, Public Health and Health Promotion
School:	Health Care Sciences
Degree:	Masters in Public Health

PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

7.2 **Appendix B.** Consent form

EXPERIENCES OF UNDOCUMENTED ZIMBABWEAN MIGRANTS ON ACCESSING HEALTHCARE SERVICES IN TSHWANE METRO, SOUTH AFRICA

INTRODUCTION

I want to thank you for taking time to meet with me today. My name is **TOM ZHUWAU.** I am a Master of Public Health student at the University of Limpopo and I am conducting a research study you're the experiences of undocumented Zimbabwean migrants on accessing healthcare services in Tshwane Metro, South Africa. he study is part of my studies for the Masters of Public Health at the University of Limpopo. Much is not known about the experiences of undocumented Zimbabwean migrants on accessing healthcare services in Tshwane Metro, South Africa. The study aims to fill in some of the knowledge gaps.

You are free to participate in the study. Your participation is entirely voluntary. You are free to withdraw from the study at any point. The interview should take less than an hour and you can stop the interview anytime if you wish. **I will need to audio record the interview as well as take notes of our discussion.** Your interview is strictly confidential and will not be shared with any other party without your explicit signed consent. Results of the interview will be submitted as a mini-dissertation to the School of Health Care Sciences, Faculty of Health Sciences of the University of Limpopo. The results may also be published as scholarly work in academic journals. No personal identifiers will be published at any point.

All interview records will be anonymised. You need to indicate your willingness to participate in the study and to the recording of the interview by signing this form below.

Please kindly note that you are not compelled to answer any question you do not feel comfortable answering.

There are no monetary or material benefits from being part of the study. However, by volunteering to participate you will help the study to understand experiences of undocumented Zimbabwean migrants on healthcare services in Tshwane Metro, South Africa.

If you need any further information or clarity about the study, please contact my supervisor, Professor Linda Skaal at the School of Health Care Sciences, Faculty of Health Sciences, University of Limpopo on 015 268 3143.

Do you have any questions regarding the study? Are you willing and consenting to participating in the study?

YES (proceed to sign this form) ☐ *Please Tick Box*

NO (end the interview. Politely thank respondent) ☐ *Please Tick Box*

_____ _____

Participant signature **Date**

7.3 **Appendix C.** Interview Guide

EXPERIENCES OF UNDOCUMENTED ZIMBABWEAN MIGRANTS ON ACCESSING HEALTHCARE SERVICES IN TSHWANE METRO, SOUTH AFRICA

A SOCIO-DEMOGRAPHIC INFORMATION

1. **Age:** ☐
2. **Gender:** Male ☐ Female ☐
3. **Level of Education:** None ☐
   Primary ☐
   Secondary ☐
   Tertiary ☐
   Other ☐

   Specify_____
4. **Marital Status:** Not m ☐
   Married ☐
   Divorced ☐
   Separated ☐
   Other ☐ Specify_____

Area of residence within Tshwane

_____

B MIGRATION HISTORY

1. How long have you been living in South Africa?

2. How long have you been living in Tshwane?

3. What are your experiences as an undocumented Zimbabwean living in South Africa? (Probe without leading the participant)

4. How have these experiences affected your life? (Probe without leading the participant)

C HEALTHCARE EXPERIENCES

5. Have you ever sought health services during your stay in South Africa?

6. What public healthcare facilities do you use when you need health services?

7. Are there any challenges you face when accessing public healthcare in Tshwane Metro? (Probe without leading the participant)

8. What are these challenges and what do you attribute the challenges to? (Probe without leading the participant)

9. What are your views of the treatment you receive from health workers at these facilities? (Probe without leading the participant)

10. What do you attribute the treatment by the health workers to? (Probe without leading the participant)

11. Is there anything else you want to share regarding your experiences seeking healthcare in the Tshwane Metro? (Probe without leading the participant)

THE END. THANK YOU

7.4 **Appendix D.** Interview transcript

EXPERIENCES OF UNDOCUMENTED ZIMBABWEAN MIGRANTS ON ACCESSING HEALTHCARE SERVICES IN TSHWANE METRO, SOUTH AFRICA

Transcript 1 (Man)

Theme	**Transcription**	**Coding**
	Interviewer: Hello! Umm I want to thank you for taking this time to meet with me today. My name is Tom Zhuwau. I want to talk to you about the experiences of undocumented Zimbabweans living in Tshwane Metro, South Africa when accessing public healthcare services. The study is part of my Master in Public Health at the University of Limpopo. Remember your participation is voluntary. The interview should not take very long for you and me to discuss all the questions I have for you. All the contributions you make are confidential unless you direct otherwise. And you must sign the consent form. Do you understand? **Participant**: Yes, I understand. **Interviewer**: OK, thank you very much. Now we start.	

	Interviewer: My first question is how long have you been in South Africa? **Participant**: I have almost three years in South Africa. **Interviewer**: Three years in South Africa **Participant**: Yeah **Interviewer**: how long have been staying here **Participant**: First time I was staying in Bronkhospruit for 2 years and half. And I come here in Tshwane maybe in 2013. So for the meantime I think I have almost one year something in Tshwane **Interviewer**: Almost one year in Tshwane **Participant**: Yes **Interviewer**: Thank you very much **Interviewer**: What are your experiences as an undocumented Zimbabwean living in South? Is it	

	easy for you to get places to live, accommodation, things like that? **Participan**t: Eeh it is so difficult for me to get places to stay especially when you still don't have, you don't know how to talk with them **Interviewer**: You don't have documents **Participant**: You don't have the document actually. It is too difficult for you to survive **Interviewer**: What about the the money they are charging for the houses? **Participan**t: As a foreigner is expensive. You just force yourself to go those expensive houses since (Interjection by interviewer: OK, OK, OK, I hear you!) you are searching for safety. (Interjection –OK) Because if you go to the cheaper there are South Africans (Yeah) if they starting to fighting (OK) or to marching for something they are going to include you as a foreigner (OK, OK). That means it is difficult for you to go to cheaper things (OK)	

	you must focus to expensive things (I see, I see, I see, OK, I see) that means you have a safety (OK, I see, I see) **Interviewer**: How have things experiences uhhh affected your life? OK, before I come to that, before I come to that, how do other South Africans treat you in the community ummm? (noise of a swinging door) **Participant**: If you want to be close to them you must know their languages. If you don't know their language they treat you like animal because they don't like, if you talk your language, like a Zimbabwean if you talk Shona you look like you are nothing to them. They treat you so bad **Interviewer**: Oh they treat you bad if you don't know their language or if they hear you speak Shona or English? Participant: Yes, Yes, they treat you so bad actually because they need you to talk their language	

	Interviewer: So you said you have been living here for that time so have you learnt any languages in South Africa in for you to communicate with them **Participant**: Yes, now I learnt almost all their languages. Out of, out of **Interviewer**: OK, OK, how many languages have you learnt? **Participant**: Now I know Zulu, Tswana, Afrikaans **Interviewer**: Zulu, Tswana, Afrikaans, what else? **Participant**: Even Venda and Xhosa **Interviewer**: Are you sure you know those languages? **Participant**: Yes, I know **Interviewer**: OK, let me just for the record I want you to maybe say something for me just a few words for me. Maybe start with Zulu. Just a few words	

	Participant: (Speaks in isiZulu) **Interviewer**: What is you say something in Sotho? **Participant**: Let me start with Xhosa **Interviewer**: OK, OK **Participant**: (Speaks in isiXhosa) **Interviewer**: OK, since you are living in Tshwane here many people speak Tswana. Can you say something in Tswana for me please? **Participant**: I am not too good in Tswana (speaks in isiZulu) **Interviewer**: OK, I see, I see, OK. Now we come to health experiences now. Have you ever had the need or have you ever fallen sick that you needed to go to the hospital? **Participant**: Yes, I have. I have fallen sick me, I think it was February 2013 but the way they treat me they didn't treat me as they treat the South African	

	Interviewer: OK, where did you go? Did you go to a government hospital or a private hospital? **Participant**: I go to the government hospital. It was a clinic **Interviewer**: They treated you **Participant**: They didn't treat me **Interviewer**: What happened **Participant**: They sent me back the very day I didn't come up with my papers and say I must bring my papers. But I was so ill so I go back and fetch those papers and comeback to the line. But they did serve me like they serve the South Africans. Our lines as foreigners sometimes they just call you, call those foreigners are coming late. But me I didn't come late. We come early but we didn't treat as well they treat the South Africans **Interviewer**: So you are saying you went back home and took your brother's papers for you to be treated	

	Participant: Yes, yes **Interviewer**: So after you had taken the papers back to the hospital, how was the treatment **Participant**: It was too slow for me as a foreigner. They just call their names, since they take their documents from our documents, since they say this is a Zimbabwean they just call those South Africans to be faster than you **Interviewer**: So you are saying if there is a line there and they know they are Zimbabweans in front of the line they jump those people and take these people at the back of the line? **Participant**: Yes **Interviewer**: Is that what you are saying? **Participant**: Ja, you as a Zimbabwean just wait. Maybe you gonna come earlier around 6 o'clock and you going to dismiss after when they knock off around 4, you they	

	going to treat you around half past 3 as a Zimbabwean **Interviewer**: So this only happened to you or does it happen to every Zimbabwean who doesn't have the papers **Participant**: It happens most of us even as Zimbabwean or someone as a foreigner. It happens mostly to foreigners **Interviewer**: So other Zimbabweans who don't have papers, how do they get treated **Participant**: They just treat as it is. You must get somebody's documents. That means you're going to have treatment. Without document they don't treat you **Interviewer**: Is it the same at the private clinics **Participant**: Ja, I just went to private documents (sic) once. But I pay a lot than when I go to the government hospital	

	Interviewer: OK, OK, I see. Ughh the workers, the healthcare workers at the clinics and at the hospitals, do you know why they behave the way they do **Participant**: I think they just want to do that. It is just their behavior. They think those foreigners are not same as they. **Interviewer**: So you are saying they segregate against foreigners, OK, OK **Interviewer**: What about if you go there, I see you speak the local languages, what if you go there and you start speaking to them in a local language **Participant**: Ja, now I have advantage. They are going to treat me as fast as they do those South Africans **Interviewer**: Because you'll be speaking a local language **Participant**: Yes	

	Interviewer: I see. So it is an advantage to be able to speak a local language **Participant**: It is an advantage. A big advantage actually **Interviewer**: I see, I see. Umm do you live alone? **Participant**: I have my wife **Interviewe**r: She has documents? **Participant**: She has document, but she is outdated **Interviewer**: Ummm, you mean it is now expired? **Interviewer**: Umm, I think we have come to the end of the interview, if there is anything you want to add umm about the way they treat you at the healthcare **Participant**: Being a foreigner and speaking a foreign language is tough in South Africa. Even if you are travelling in a taxi, or at a wedding, or anywhere. When you speak in Shona or Shangaan they	

	look at you as if you are crazy. Even when we are at a *lobola* ceremony and your phone rings and you answer in Shona or Ndebele they start calling you names such as *kwerekwere*. They even call you a dog and it not only black South Africans who do this. Afrikaners do the same to us. **Interviewer**: I see. Thank you so much for availing yourself for an interview. We have come to the end of our interview. **Participant**: Thank you too.	