Healthy Migrants or Health Migrants?

Accounting For the Health Care Utilisation Patterns of Zimbabwean Migrants Living in South Africa

By

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ABSTRACT

Background: There is a long history of migration between Zimbabwe and South Africa. In recent years there has been a significant increase in the mix of Zimbabweans migrating to South Africa in search of better economic opportunities, fleeing political persecution, to pursue education. Little is known about the public health impact of this migration, the healthcare needs of the different categories of migrants, as well as their health-seeking strategies. The report aimed to explain the patterns of health care utilisation of Zimbabwean migrants in Johannesburg.

Methods: A descriptive exploratory research design was adopted in which two methods were applied. First was the use of existing quantitative data from a recently completed survey (RENEWAL 2008) in which Zimbabwean migrants were the prominent international migrant group (n=118). Second, follow-up qualitative in-depth interviews with four respondents, were conducted to explore in detail specific cases where respondents used a public healthcare facility or where they had to make a difficult decision due to illness in a foreign country.

Results: The majority of Zimbabwean migrants do not seek healthcare in South Africa neither do they report "ever falling ill" after arriving in the country. Out of 118 respondents only 25 reported an illness incidence of which 17 sought help from different health service providers, 11 of them at a government health facility. None of them was denied on the basis of their legal status. Some of the users of healthcare services, were satisfied with the treatment they received.

Conclusion: There is little evidence in the findings to support the hypothesis that legal status is a deterrent factor among migrants who seek treatment at government hospitals. Instead factors such as proximity of the healthcare facility to the respondent's place of residence were the more important reasons in choosing a certain healthcare provider. Also the generally low utilisation tendencies could be attributed to the "healthy migrant hypothesis". A survey with a larger sample size could establish more diverse patterns of health care utilisation among Zimbabwean migrants in South Africa.

DECLARATION

I **Nedson Pophiwa** declare that this research report is my own unaided work. It is submitted for the degree of Master of Arts in Forced Migration Studies at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

Signed: _____

Date: 31 August 2009

DEDICATION

To my daughter Landirani Nokutenda Pophiwa

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CHAPTER 1: INTRODUCTION

"Health is a state of complete physical, mental and social well-being not merely the absence of disease or infirmity"

-The World Health Organisation's definition of health[1]

Zimbabwean migration to South Africa has increasingly become topical, particularly at the time of researching on this topic (in 2008) when a series of marked events took place. First was the raid on the Central Methodist Church in Johannesburg by the South African Police. The church is known to be home to above one thousand five hundred migrants mostly of Zimbabwean origin. Secondly the year witnessed the callous xenophobic attacks on migrants across the country which led to the murder of 62 people. Third, living conditions in Zimbabwe began to deteriorate to alarming levels with the outcome of the March 2008 elections and the one party election re-run of June 29 of the same year which saw the ruling party ZANU PF maintain its grip to power. Since November of that year Zimbabweans suffering from cholera have been receiving treatment in the South African Musina border due to the shortage of medicines in their country. This situation presented for the first time a clear example of migration occurring for the purposes of accessing healthcare.

This study set out to explore the factors which determine the utilization of public health facilities in Johannesburg by Zimbabwean migrants in South Africa. In so doing, it set out to describe and also explain the different patterns of health-seeking behaviour in relation to the utilization of health care services. The study probes the patterns of health care utilisation of migrants from their perspective by describing their situational characteristics (e.g. length of stay, age, marital status, ethnicity, religion, language proficiency, employment etc) and attitudinal characteristics (e.g. perceived health status and acculturation). In the case of Zimbabweans, who have grown exponentially in number (Landau 2008, Makina 2008) over the past few years

[1] Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946, signed on 22 July 1946 by the representatives of the 61 states (Official Records of the World Health Organisation, No.2, p.100) and entered into force on 7 April 1948

and are arguably the largest number of migrants in South Africa, it is important to explore their utilization of public health care facilities (especially the hospitals) be it for emergency, maternity or outpatient treatments. It is worthwhile to understand whether length of stay, legal status (which may instil perceived fear of detection), health status or other financial and non-financial barriers explain their patterns of health care services utilization in South Africa at this point in time.

The study also considers some of the widely held views on trends of health care use by migrants in South Africa, among which are claims that migrants migrate in order to use 'better-off' health facilities in South Africa and that migrants tend to bring disease. It also builds upon preceding migration research findings (CORMSA 2007; Migrant Health Forum 2008) which indicate that a significant proportion of African migrants do not utilise public hospital facilities in South Africa. Due to the advocacy nature of that research, the under-utilization of hospital services is largely attributed to institutional flaws in service delivery. On the contrary the findings of this study show that Zimbabwean respondents rated the standards of South African public hospitals as high and a number of them did not face any discrimination in accessing healthcare. Most of the respondents indicated that they had never been ill during the last twelve months in South Africa, and amongst those who reported an illness incidence, they reported minor ailments. But before we delve into the findings, the following section gives a background to the study.

1.1 Background

There is a long history of migration between Zimbabwe and South Africa dating from the pre-colonial times. It is beyond doubt that these migration patterns have been produced, influenced and shaped by different events throughout history from the time of *Mfecane* through to the advent of colonialism and the present post-colonial dispensation. From the 1840s onwards, Zimbabweans were among some of the Africans from Southern Africa already coming to work on the cane fields of Natal and the diamond mines of Kimberley (Crush 1995; See also Worger 1987, Harries 1994). There has been significant scholarly attention, particularly on the migration patterns during the colonial period when the major reasons for migration to South Africa were linked to labour. Unskilled and semi-skilled Africans from colonial Zimbabwe,

Botswana, Lesotho, Swaziland, Zambia and Malawi were often lured by the Rand into South Africa (Van Onselen 1982). We learn from history how the South African labour recruitment agency, the Witwatersrand Native Labour Association (WENELA) recruited clandestine labour from Southern Rhodesia and the rest of the Southern African region and was preferred to its rival in Southern Rhodesia, the Rhodesia Native Labour Bureau (RNLB). In addition the new international migrants sought work, where they lived and their lifestyles on the farms and mines of South Africa. In the same vein scholars have tried to explain some of these aspects of migrants' lives in various ways, for instance it was argued that as target workers, these labour migrants would work only until they were able to buy the commodities that they targeted such as a bicycle, a bed or even to raise *lobola,* particularly for single young men (Crush 2000: 14).

It can be noted however, that Zimbabwean migration to the South African mines during the colonial period and the first decade of post-1994 South African democracy was not as significant as that of migrants from other neighbouring countries. The migration of Zimbabwean contract workers to the South African gold mines was smaller than that of neighbouring countries mostly because colonial Zimbabwe had a vibrant mining industry and employment opportunities. The largest number of workers came from Malawi, Mozambique, Lesotho, Botswana and Swaziland (see Appendix 1). Other countries that supplied the mines with labour were Tanzania and Angola as well as Zambia. On the whole it can be tentatively argued that the migration of Zimbabweans into South Africa during the pre-2000 period was relatively low and began to gain momentum with the failure of the government led by ZANU PF.

An interesting dimension to the history of labour migration to South Africa is that of the medical impacts of migration. The impact of poor safety and its hazards to mine workers are well-documented (Molapo 1995; Crush 1995; Packard and Coetzee 1995). Added to this were the living conditions in the mine compounds and men's hostels that have been linked to the spread of venereal diseases. Colonial officials repeatedly expressed concern at the rate of spread of these diseases. In some cases non-infectious diseases were common among migrant workers. Take for example Molapo (1995) explores the social risk factors that made migrant Basotho

mineworkers in South Africa vulnerable to non-infectious chronic diseases such as cardiovascular diseases. Amongst the greatest health problems indicated by the mineworkers were issues caused by fear of dying or being crippled in mine accidents, particularly rockfalls. Her study also established that most workers who showed signs of fear abhorred everything connected to mining such as the underground work, compound life and (human) labour relations on the mine (1995: 89). Amongst the most common diseases on the mines was Tuberculosis as a result of poor ventilation and other causal factors of the disease. Whilst the history of TB on the mines is not within the scope of the study it is worthwhile to mention that there was a sharp increase in incidence of TB during the 1970s even though in the previous decade there had been a decline resulting from improvements in case finding and treatment (Packard and Coetzee 1995: 109). Mine medical authorities argued that the rise in TB was due to four factors, namely; the increasing background levels of TB in the areas from which they drew labour; better case detection; the introduction of HIV on the mines and lastly; the increasing age of their work force (Packard and Coetzee 1995: 110).

The second last causal factor of TB is interesting because studies have shown how the apartheid regime reacted to the growth of HIV infection on the mines. In October 1987 the apartheid state prohibited the immigration of HIV carriers and AIDS sufferers into the country (Chirwa 1995: 120). It became a punishable offence for an individual or institution to knowingly help an HIV positive person to enter or stay in South Africa and all those entering the country for work or study purposes were supposed to produce an HIV-free certificate issued not more than two weeks prior to their entry. This had an effect on migrant labour as Chirwa's study of Malawian mine workers in South Africa shows reveals that about 101 mining recruits were repatriated for being HIV+ in February 1988 and a month later the Chamber of Mines stopped importing labour from Malawi altogether (1995: 120). South Africa began to categorise Malawian migrants as a high-risk group and their country as a high-incidence area.

Drawing from these few examples on how migration and health were linked during the apartheid era it is evident that colonial authorities paid attention to problems regarding migrants' health. The debate on migration and health linkages had already

started and as will be shown in this discussion, this continues to be a hotly contested area of enquiry. The section that ensues explains some of the historical challenges faced by the South African health system.

1.1.2 The SA health system and challenges of inequality

From 1948 to 1994, racial discrimination against all black people affected people's health in many ways. These included; social conditions which caused ill health; the segregation of health services; racially biased unequal spending on health services and the general failure of professional medical bodies and civil society to challenge apartheid health policies. Take for instance the unequal spending during the apartheid era. In 1982 the entire health budget for KwaZulu, then a "semi-independent" Bantustan with more than five million people under the leadership of Mangosuthu Buthelezi was equivalent to the entire budget for Johannesburg General Hospital, then a "white only" hospital (Hassim et al 2007: 13). This legacy from the apartheid system continues to bedevil progress in ensuring the democratic rights to health as intended by the new South African government of the African National Congress (Hassim et al 2007: 11).

The post-1994 era up to the present therefore has witnessed a continuation in the challenges facing the Department of Health (DoH). There are continuing inequalities and imbalances between the public and private health sectors e.g. the infant mortality rate (IMI) among wealthy citizens is 8 deaths per 1000 live births and among the poor it is 64 deaths per 1000 live births (Leatt et al 2006). There is a severe shortage of doctors, nurses and pharmacists particularly in the poorer (and more rural) parts of the country. The HIV/AIDS pandemic continues to be a challenge for response and prevention programmes. Aggravating the issue is the failure of the DoH to fulfil its legal duties and to ensure that the laws and policies it adopts are in keeping with the progressive constitution. There has been dissatisfaction among users of the system complaining about long queues, long waiting times, staff rudeness and problems with the availability of drugs (Burger 2007).

It is important to take note of the challenges being faced by the public health sector because due to the worsening political and economic climate in South Africa, the sector is increasingly becoming the sole healthcare provider for the poor. In a keynote address on the challenges affecting the National Health System, the Chief Executive Officer of the Human Sciences Research Council noted:

> Unfortunately, the results of these policies, devoid of a consensus approach to addressing the health system challenges further exacerbated inequalities; more people who have medical aid have since lost it. Consequently, more people than before now rely on the public health system or are forced to use the public health sector because they cannot afford the cost of medical aid.

Therefore this is a situation which needs intervention because the South African public health system is increasingly facing demand from its local population yet poor international migrants also need to utilise the same services.

While a move to South Africa would in theory be a beneficial to a migrant from a resource-poor country, the gains are limited in practice due to several constraints in healthcare service delivery. For now, the segments that follow will try to situate the present trends of Zimbabwean migration in South Africa and implications on health care as well as a brief note on the Regional Network on AIDS, Livelihoods and Food Security (RENEWAL) project which contributed significantly to this study.

1.1.3 A Profile of Zimbabwean Migrants in South Africa

Since 1980 one could argue that there were three episodes of migration from Zimbabwe to South Africa. The immediate post-1980 period witnessed the emigration of whites who had formally worked in the colony relocating to South Africa (Sisulu et al 2007). Secondly the fleeing of Ndebele speaking ethnic groups from the massacres of *Gukurahundi* that were being unleashed by the Mugabe-led government between 1983 and 1987 (Sisulu et al 2007). This wave of migration is not easy to document considering the invisibility of the Ndebele who have cultural and linguistic affinity with the Zulu of South Africa. Most of these migrants have also obtained citizenship in the country and remain invisible. Thirdly, Zimbabwean professionals began to

leave the country in the late 1990s in smaller groups to seek greener pastures only to accelerate in the post-2000 period (Sisulu et al 2007: 554). Simultaneously Zimbabwean women were increasingly engaging in cross-border trade as a survival strategy in neighbouring countries (see for example, Zinyama 2000, Muzvidziwa, Chipemebere 1999, and Pophiwa 2007). Also this period has experienced new categories of migrants such as refugees, asylum seekers, students, unaccompanied minors and skilled workers etc who are forced to migrate due the status quo in Zimbabwe. An interesting observation has been made regarding the migration of Shona-speaking migrants who did not traditionally migrate to South Africa as the Ndebele:

> A few years ago, it was not common to hear Shona being spoken in Johannesburg or any other South African city. Nowadays it is rare to move around without hearing snatches of conversation in Shona, especially in restaurants and shopping centres. (Sisulu et al 2007: 555)

The presence of Shona-speaking migrants can also be used as an indicator of the diversity of Zimbabwean migration as well as to certain extent evidence that there has been an increase in Zimbabweans in South Africa. The table below illustrates these different categories:

CATEGORY	DEFINITION
Refugees	who are fleeing *individual* persecution, and those who are fleeing *group* 'political' persecution such as Murambatsvina, etc.
Humanitarian migrants	who are fleeing extreme deprivation or starvation for themselves or their families
Economic migrants	including highly skilled and unskilled, who are often aiming to work in order to support struggling families in Zimbabwe
Traders	who move back and forth between SA and Zimbabwe regularly to buy and sell goods
Shoppers	who enter SA to shop for food and basic goods and return to Zimbabwe almost immediately
Borderland residents	who move back and forth regularly while remaining in the border area
Transit migrants	who come into South Africa with the intention of moving on to another country relatively soon
Unaccompanied minors	who either remain in the border area or move to the urban areas

Table 1: Categories of Zimbabwean Migrants in South Africa
Source: FMSP Report (2007)

Some of the categories mentioned above tend to overlap. Border residents may, due to circumstances decide to go beyond the border land into the greater cities in search of opportunities to become economic migrants. Humanitarians are likely to apply for an asylum seeker permit. The health care needs for each group vary.

In principle Zimbabwean migrants, some who have fled economic hardships are ineligible for asylum as they are not fleeing war or political persecution in their country. With an officially reported inflation rate of 231,000,000% as of July 2008 (whilst the alternate figure could be in the quadrillion range); an unstable currency and other exacerbating factors, life has become unbearable for the ordinary people in Zimbabwe (Business Media International 2008). Added to this is the collapse of the public health delivery system in the country which is not only affected by high costs of treatment, but staff drain (unoccupied positions are as high as 40%), obsolete infrastructure and "bare dispensaries" (Zimbabwe Independent, 7 March 2008). About 1,700,000 people are living with AIDS in Zimbabwe, and life expectancy is lowest in the world standing at thirty seven for men and thirty four years for women (Human Development Report, 2005). At the time of writing this paper, cholera has become an epidemic killing nearly 1700 people in Zimbabwe and had spread to the border town of Musina, where a significantly number of Zimbabweans were treated for cholera. Zimbabwe declared a national health emergency due to the outbreak but that was after nearly 560 people had died (The Guardian, 5 December 2008). It is perhaps the bulk of migrants fleeing poverty and in search of greener pastures that come through unauthorized entry points or legally through visitors' visas that end up becoming undocumented migrants in South Africa. Being undocumented, means that these migrants have limited basic rights to accessing employment, housing and health in the host country.

It can be noted that from different studies conducted on Zimbabwean migrants in South Africa, there have been various categories of migrants and claims or reasons for their migration but a significant proportion of the categories are constantly changing and the claims remain merely as myths. Concerns have been raised on the tendency by media and state officials to refer to 'millions of Zimbabweans' crossing South African borders and 'flooding' the cities everyday as this does not seem to be realistic. Take for instance, 'demographic guesswork' has estimated that there are

between one and three million Zimbabweans living in South Africa (Forced Migration Studies Programme and Musina Legal Advice Centre 2007: 4). These figures project a provocative image of a Zimbabwean 'Human Tsunami' sweeping across South Africa (FMSP and Musina Legal Advice Centre 2007: 4). In essence these figures are generally cited in an effort to imply that migrants constitute a massive and unwarranted drain on South African public services and the notion of migrants as opportunists is rubbed in with the aid of these numbers such that an image of a subtle invasion of South African territory that needs immediate and direct response is created (Vigneswaran 2008: 144).

There are also tendencies to group all Zimbabweans as one category of migrants, mainly economic migrants. In essence, labelling them as economic migrants distorts the picture of Zimbabwean migrants as a homogenous group yet some have fled the country for political persecution (as political activists) and others fled social problems such as domestic violence, among other things. Labelling also opens up the debate on the recognition of the political and economic situation of the country as entitling them to become refugees and hence it has become highly politically charged among different political parties in South Africa. On one extreme, the Democratic Alliance has supported its call for camps by referring to Zimbabweans as 'economic migrants' whilst on the other, the Department of Home Affairs has supported its rejection for setting up camps by arguing that none of the Zimbabweans legitimately qualify for asylum protection (FMSP and Musina Legal Advice Centre 2007: 5).

Not only is it political in the sense that South African political parties have been debating the Zimbabwean crisis and migration of its citizens within the Southern African region, but in some circles the influx of Zimbabweans fleeing their country has been used to support claims that South Africa's mediation role has failed in Zimbabwe. It is thus worth acknowledging that there is heterogeneity in the nature of Zimbabweans crossing into South Africa and they do so for a variety of reasons for example refugees, humanitarian migrants, economic migrants, traders, shoppers, borderland residents, transit migrants and unaccompanied minors—a list which is not exhaustive (FMSP 2007: 7). Thus my study is concerned with these categories of migrants and tries to situate the impact that these migration patterns have had on the health needs of Zimbabwean migrants.

1.1.4 Zimbabwean Migrants and Health Care in South Africa

At one time or other in their life in the country of destination (in this case) South Africa, migrants need to utilise health care facilities. As Evans has noted that migration compels the migrant to adjust to a new lifestyle which often brings with it a new set of health risks (Evans 1987). There are several unfounded claims with regards to the use of health care facilities in South Africa by Zimbabwean migrants, in particular. The initial claim refers to Zimbabweans and other African migrants as coming to South Africa primarily to seek medical care especially Antiretroviral Therapy (ART) which is free in public hospitals. Much of this is based on anecdotal evidence and a few media claims. However it appears from recent research in Johannesburg that migrants do not come to South Africa primarily to seek treatment in hospitals. In the case of one recent survey with a total number of 449 respondents revealed that most migrants tested HIV positive only after they had moved to South Africa (Migration Health Forum 2008). This study found that migrants are healthy upon arrival in South Africa and migrated for reasons other than health; such as economic hardships and escaping conflict. Their presence in South Africa may be the reason why they end up seeking health care. It is equally interesting to note that the majority of international migrants travel from a country of lower HIV prevalence to South Africa, where there is the highest population of people living with HIV in the world (Migrant Health Forum 2008: 6).

With reference to the utilisation of health care facilities by migrants research by the Migrant Rights Monitoring Programme has shown that less than half of the 1190 respondents in the survey indicated that they ever needed health care in South Africa (cited in the Migrant Health Forum Report 2008: Appendix F). Only 30% of the respondents in that survey indicated that they had ever sought health assistance and their main barriers constituted provider attitudes and unnecessary request for documentation (are all in contravention of the Department of Health policy and directives) (Migrant Health Forum 2008: 6). Also drawing from a correlation between length of stay and chances of having ever needed health care (i.e. the longer you stay in South Africa the more likely you are to need healthcare) actually proves

that these are not health migrants (Migrant Health Forum 2008: 6). A recent discussion held by the South Africa Futures-Zimbabwe-Futures Forum acknowledged that the link between this huge Zimbabwean migration and public health in South Africa is not adequately understood or accurately documented.[2]

1.2 Scope of the project

This report explores aspects of health care utilization by African migrants in South Africa, particularly focusing on Zimbabweans. It tries to establish the patterns of health care use by exploring the determinant factors of utilization among this group of migrants. The fact that less than half of the migrants in the Migrants Rights Monitoring Project indicated that they ever needed health care warrants further investigation into the trends of health care utilization among migrants. This is in the light of advocacy research which focuses on institutional flaws (from a rights perspective) as major determinants of health care utilisation by migrants. This present study therefore tries to probe the patterns of health care utilization of migrants from their perspective by explaining their situational characteristics (e.g. length of stay, age, marital status, ethnicity, religion, language proficiency, employment etc) and attitudinal characteristics (e.g. perceived health status and acculturation). Nevertheless, Zimbabweans, who have increased rapidly in numbers among the forced migrants population in South Africa during 2008, it is interesting to explore their utilisation of public health care facilities especially the hospitals be it for emergency, maternity or outpatient treatment. It is worthwhile to explore whether length of stay, legal status (which may instil perceived fear of detection), health status or other financial and non-financial barriers explain their patterns of health care services utilisation in South Africa. Perhaps Zimbabwean migrants return home to seek medical care. However, some studies have shown that Zimbabweans ranked health care problems the least among their grievances lists (Landau 2008, Makina 2008).

[2] The South Africa-Futures-Zimbabwe Futures Forum was hosted by the University of the Witwatersrand on 31 October 2008.

1. 2.1 The Research Question

The main research question and sub-questions are as follows:

1. What factors determine the utilization of public health facilities by Zimbabwean migrants in Johannesburg?
    a) What socio-economic and legal factors influence the utilization of health care services by Zimbabweans in South Africa?
    b) What are the actual experiences of Zimbabwean migrants who have tried to access health care in public hospitals?
    c) Do Zimbabweans living in Johannesburg have alternative sources of health care and how do they use them?

The study hypothesised that Zimbabwean migrants—particularly undocumented—are most likely to avoid utilising public hospitals when seeking treatment and use alternative sources of health care. So the assumption is that for the most part when confronted with legal barriers, hospitals are only likely to be one of the available options since migrants could draw on private healthcare (depending on affordability), traditional health care, and also their links with home.

1.2.2 The RENEWAL Project

The Regional Network on AIDS, Livelihoods and Food Security (RENEWAL) study facilitated by the International Food Policy Research Institute (IFPRI) is a regional "network-of-networks" in five countries of Sub-Saharan Africa.[3] Taking a livelihoods approach, RENEWAL situates the determinants and impacts of HIV and AIDS and the responses to the disease within the frameworks of people's lives (IFPRI, RENEWAL Summary, 2006). Among its major objectives[4] one that is of interest to my study seeks to:

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[3] RENEWAL is currently active in five 'hub' countries (Malawi, Uganda, Zambia, South Africa and Kenya) and comprises national networks of food and nutrition-relevant organisations (public, private and nongovernmental), together with partners in AIDS and public health. (www.ifpri.org/renewal)

[4] The other objectives are as follows: (1) Demonstrate that household level rural food production contributes to the food budget of urban households through urban-rural linkages; (2) Examine the role of rural-urban migration and rural-urban linkages at the household level in magnifying or ameliorating the impacts of AIDS on urban household food security; (3) Quantify the role that urban agriculture plays in meeting the food gap of urban households, and the extent to which AIDS influences this; (5)

1) Assess the policy environment's role in hindering or contributing to the urban food security of households (urbanization, economic, health –including AIDS - and education)

The South African case study of RENEWAL was undertaken by the University of the Witwatersrand Forced Migration Studies Programme and likewise set out to explore the linkages between HIV, migration and urban food security (see RENEWAL, South African Report 2008). The survey looked at three groups of respondents (n=489) namely, internal South African migrants, international African migrants and a control group of South Africans who had always been living in Johannesburg—the research site. Due to the sampling of the project it turned out that the dominant African migrant group was of Zimbabwean nationality (n=118). The Zimbabwean migrant group is of interest and the findings provide quantitative data for this study. This study draws from the RENEWAL study by analysing the health-seeking behaviour patterns and patterns of health care services utilisation by Zimbabwean migrants in Johannesburg who participated in the survey.

1.2 Structure of the report

The report is structured into six chapters. The current chapter introduces the report by providing a background to Zimbabwe-South Africa migration patterns, a profile of Zimbabwean migrants and their health care needs in South Africa and then it explains the scope of the study. The second chapter reviews the literature on migration and health as well as health-seeking behaviour. The same chapter discusses the theoretical models that will be used to interpret the findings of the report. Chapter three describes the methodological approach that was used in the report. The fourth chapter presents the findings, whilst a discussion of the findings is carried out in the fifth chapter. This is followed by a concluding chapter, which sums up the whole report.

Identify policy and programming implications of the findings in the context of the triple challenge of migration, AIDS and food insecurity; (6) Identify problems and challenges that are specific to orphans and vulnerable children as a critical element of society within the regional context of migration, AIDS and food security

CHAPTER 2: LITERATURE REVIEW

Not all problems associated with migration become 'migration health problems.'
- Roux and van Tonder (2006)

2.1 Introduction

This chapter reviews the literature on migrant's health needs, issues of health services utilisations and overall access to health care. Much of this literature has mainly focussed on the migration health aspects of migrants from the South who migrate to the North, but of late some studies have begun to document South-South migration health aspects. As in the latter sense, the present study contributes to the literature on south-south migration health issues by studying the utilisation of healthcare services by Zimbabwean migrants in South Africa. The chapter also discusses the theoretical framework adopted in the study. The study is informed by several models of health-seeking behaviour that will provide a lens through which to interpret the findings.

2.2 Migration and Health

The health dimension of migratory movements is becoming ever more prominent in response to the large and increasing number of people who are travelling geographical, cultural and ecological boundaries on a regular basis in a variety of capacities (Carballo cited in Roux and Tender 2006). According to Besseling (cited in Roux and Tender 2006: 120) migration health refers to 'health issues, conditions and risks related to mobile populations and to the way in which they affect 'migrants, their families and communities, the population of …origin, and the [population] of destination…' A number of variables is considered in migrant health such as physical health, functional health, psychological health, health-seeking behaviour, and the accessibility and inaccessibility of health care (Roux and van Tonder 2006:121). Traditional bio-medical approaches dealing with migration and health have focused on the recognition, identification and management of specific diseases, illnesses or

health concerns in mobile populations at the time and place of arrival (Gushulak et al 2006). The underlying principles of such approaches are the desire to protect the recipient population by exclusionary policies directed at the migrants or travellers (Gushulak et al 2006).

Migration has been viewed as the 'structure that causes migrants to fall ill' but rarely considered as having positive outcomes such as the improvement of migrants' health status. Evans (1987) argues that migrants tend to have two characteristics that can greatly affect the demand for health services at the local level—they tend to be young and they tend to cluster in small geographic areas. That they are young implies that they will demand a different set of health services than the population at large. This will be felt mostly in the elevated demand for emergency services, internal medicine, dentistry, obstetrics, gynaecology, and paediatrics. That they are geographically clustered implies that the medical capabilities of the health care infrastructure could be greatly stressed in the areas that migrants reside (Evans 1987).

The relationship between migration and health can be conceptualised as follows; firstly, health can be either a positive or a negative condition for migration. Labour migrants, for instance, need to be healthy to improve their probability of successfully selling their only commodity, their labour. On the other hand, some individuals might elect to migrate in order to access health services that are not available at their home place. An individuals' poor health can however, deter or prevent him or her from moving (Roux and van Tonder 2006). A migrant's health status can also be a consequence of migration. Migratory movements can have far-reaching effects in the health of individual migrants during the reception phase.

The table below adapted from Gushulak and McPherson (2006) summarises the relationship between migration and health in different phases of mobility.

Occurrence	Examples	Consequence at destination
Pre-departure existing medical condition	-prevalence of endemic disease -level of development -access to care -availability of care	Arriving population displays health indicators of origin: • Differing incidence & prevalence of illness • Differences in awareness of & use of healthcare services: • Preventive • Promotional • Diagnostic • Therapeutic
Health impacts during migration	-trauma (physical-psychosocial) -deprivation -violence -exposure -injury	Some populations display greater prevalence of illness resulting from torture, trauma, abuse & exposure • Refugees • Refugees claimants or asylum seekers • Trafficked/smuggled migrants
Health impacts arising after arrival	administrative/legal limits -poverty -language culture -occupational risks	Awareness of & use of healthcare services in migrant populations may be limited by immigration status, poverty, language & culture Working conditions may be associated with health risks: • Migrant agricultural labour • Commercial sex workers • Illegal workers • Trafficked migrants
Health consequences of return travel	Health environments at origin may have changed -health systems improvements or declines Children born to foreign-born parents have no exposure to risks present at origin	Populations making return journeys to place of origin (particularly children born at new destination) may be at increased risk of disease or illness: "Visiting friends & relative" travellers -Locally born children of foreign-born parents

Table 2: The impact of different health environments and the phases of population mobility

Source: Gushulak and MacPherson (2006)

As indicated in the table above, upon arrival migrants are exposed to several conditions that exacerbate their health status or conditions. Not only is there a possibility for deterioration in health status but migrants may fail to seek healthcare

treatment as they did in the pre-migration phase because of barriers that may be posed in the host community such as legal status and hostility by host service providers. Due to economic hardships in the host country, migrants may face difficulties in accessing quality healthcare due to affordability constraints and also deprivation to accessing essential social services could lead to deterioration in their health standards. It would be interesting in the light of these theoretical assumptions to explore the factors that influence the manner in which Zimbabwean migrants seek healthcare treatment, the experiences they face, in South Africa etc.

Of importance is the link between HIV/AIDS and migration. There are several case studies of migration and HIV/AIDS in Southern Africa both by academics and policy makers (Veary 2008; Lurie et al 2006; Crush et al 2005; Kahn et al, 2003). Migration is tied to the rapid spread and high prevalence of HIV/AIDS in the following ways: migrant communities are socially and economically marginalised and have high rates of infection; migrant social and sexual networks make them more vulnerable to infection; migration encourages high-risk sexual behaviour. In terms of prevention, migrants tend to be left out of HIV/AIDS intervention programmes due to their settlement patterns, which often find them in informal settlements or in rural areas (mining/agriculture) that are difficult to access or do not have health facilities (Landau 2008: 184). Added to this mobile populations, who are fortunate to access Anti-Retroviral Treatment (ART) may experience challenges in adhering to treatment, which could contribute to the spread of multi-drug resistance strains (Ibid: 186). Lurie argues that "Although little work has been done among those populations the dynamics of HIV/STI spread among refugees is likely to be quite different from that of urban male migrants living in single sex hostels (2005: 304).

Research has also shown that border towns have high HIV prevalence mostly because these are areas where truck drivers encounter stable local populations, and are less exposed to AIDS intervention programmes (Crush et al 2007; see also Wilson 2000a, Wilson et al 2000; IOM). Some studies illustrate that migrant domestic workers are also vulnerable to increased HIV infection as a result of their gender, migrancy, social isolation, poverty, low levels of education, lack of access to health-care services and lack of power at work and possibly at home (Dinat and Peberdy 2007; see also IOM/CARE 2003, IOM/UNAIDS 2003). Refugees and Internally Displaced Persons

are also especially vulnerable to HIV infection. The table below summarises the major empirical studies conducted on Migration and HIV/AIDS in Africa as at 2005.

Location, year (Authors)	Population	Main Findings
South Africa, 2003 (Lurie et al.)	Migrant men & their partners, & non-migrant men & their partners	Migrant men 2.4 x more likely to be infected with HIV than non-migrant men; high rates of HIV discordance among couples; women the infected partner in 30% of discordant couples
South Africa, 2003 (Zuma et al)	Migrant & non-migrant women near a South African mining town	HIV prevalence among migrant women was 46%; migrant women were 1.6 times more likely to be HIV-infected than non-migrant women
Uganda, 1995 (Nunn et al)	Rural Ugandan residents & migrants	People who moved within last 3 years were 3 times more likely to be HIV infected than those who had residence for 10 years.
Senegal, 1993 (Pison et al)	Seasonal migrants in rural areas	HIV spread mostly first to men who became infected during seasonal migration, then to their rural partners when they returned
South Africa, 1992 (Abdool Karim et al)	Rural KwaZulu-Natal residents & migrants	HIV 3 times more likely among those who had recently changed their place of residence
South Africa, 1991 (Jochelson et al)	Urban male mine workers	Migration disrupts family life and creates a market for prostitution in mining towns
Zimbabwe, 1990 (Bassett et al)	Urban male factory workers	HIV+ men more likely to live apart from their wives and to have multiple sex partners

Table 3: Summary of the major African studies on Migration and HIV/AIDS

Source: Lurie (2005)

Lurie (2005: 298) concludes that migration, or population movement has played a critical role in the spread of HIV throughout Southern Africa, but relatively few studies have attempted to understand the underlying processes in detail or develop ways to reduce the spread of infection among migrants and their partners.

2.3 Migrants and utilisation of healthcare services

2.3.1 Literature on experiences of migrants in developed countries

There are several scholarly works on migrants' health needs, health services utilizations and overall access to healthcare. The bulk of this literature focuses on the medical experiences of undocumented migrants in the United States and other developed countries (Teller 1973; Nickel 1986; Wilson and Rosenberg 2003; Correa-Velez 2005; Ross et al 2006; De Luca 2008). This work has mostly been concerned

with addressing problems associated with an exclusionary policy towards migrants' access to non-emergency healthcare. For example, through the Federal Welfare Reform Act of 1996, the Governor of California tried unsuccessfully to enact a law that would cut off expenditure on prenatal care for undocumented migrants (Menjivar 2002). Another example is that of Spain, where the right of the immigrant population to health and healthcare is regulated by a set of laws dealing with immigration and naturalisation: healthcare is guaranteed for minors and pregnant women, persons with a medical emergency, and immigrants registered with their local census bureau (Buron et al 2008). Grove and Zwi (2006) concur that there have been inadequate responses by developed countries to the health needs of refugees and forced migrants. Undocumented migrants have also been excluded from the state's list of marginalized populations who are entitled to subsidized health care facilities (PICUM 2007). The debates on exclusion of migrants in healthcare access have also come under criticism because in order to ensure the wellbeing of citizens there is need to make sure that the health of migrants is considered especially in the fight against diseases such as HIV/AIDS (Smith 2001).

Other studies show how the 'hidden' migrants find ways of accessing healthcare of some sort especially migrant women who rely on their networks with families back home or through "ties that heal" (Menjivar 2002). They also show how these groups circumvent issues pertaining to health insurance and also the flip side of an apparent fear of detection and deportation by accessing healthcare (Chavez et al 1992; Yebei 2000). Some findings have shown that immigrants in developed countries such as Spain overcome certain barriers by using the emergency department to access health specialities in preference to other routes (Buron et al 2008).

2.3.2 Literature on experiences of migrants in South Africa

What scholars on healthcare issues of migrants in developed countries say, shows some differences from the situation in South Africa where the Bill of Rights and Refugees Act (1998) provide for health care access of migrants to medical treatment

including non-emergency needs especially of refugees and asylum seekers. Article 27 of the South African Constitution on "Health care, food, water and social security" reads:

1. Everyone has the right to have access to:
    a. Health care services, including reproductive health care;
    b. Sufficient food and water; and
    c. Social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
3. No one may be refused emergency medical treatment.

Most of the work has therefore 'naturally' looked at the flaws in providing healthcare to undocumented migrants. Amongst the difficulties that Somalis have experienced in accessing health care in South Africa are issues relating to the inhospitable treatment by hospital staff which in most cases has been attributed to xenophobia (Pursell 2005). Other work precisely of advocacy in nature has gone further to look at the shortcomings of the programme on antiretroviral treatment (ART) for undocumented migrants in South Africa mostly because there are ambiguities in the rights of these people to access such treatment (CORMSA 2007; 7). These works illustrate the practical problems of health access obtaining on the ground which differ from what is provided by the law, for example, health personnel discriminating against migrants on the basis of language barriers or ignorance of refugee rights and also xenophobia. Therefore if it is not the state's conscious effort to deny migrants access to healthcare especially in public hospitals that constitutes barriers to healthcare for migrants in South Africa, then perhaps there is need to look at other factors as they are explained by scholars.

The forced migration literature views institutional flaws as major obstacles to access to social services in general and health care in particular. For example the incompetence of the Department of Home Affairs in registering *bona fide* refugees and asylum seekers means a denial of legal protection for this vulnerable group and equally a denial to state services (Landau 2008). Thus in a case where a refugee needs ART the situation is complicated if the registration for that individual takes long

because the permit is a pre-requisite for accessing treatment. Resultantly non-citizens or migrants face challenges in accessing ART in the public sector in South Africa (Veary 2008). The attitude of hospital staff is also an important obstacle to the accessing of not just treatment but quality treatment as some studies have shown (Pursell 2005; Landau 2007).

The living conditions of migrants in South Africa are argued to be potential causal factors for the deterioration in their health status. Singh (2005) notes that not only do new arrivals (both domestic and international) often live in over-crowded residential units, but they also have little access to public health facilities even though they are constitutionally entitled to them. She further cites data from the Agincourt field site, which shows that factors associated with being a settled former-refugee appear to produce an inequitable burden of child mortality due to lack of legal status and social and economic barriers, which have negative consequences, such as poor access to health and social services, as well as indirect negative consequences, such as social discrimination and marginalisation (Kahn et al, cited in Singh 2005: 26). Pursell (2005; 11) argues that the risk factors that come with emigration to South Africa provide strong motivation for forced migrants to be enabled to claim and receive the right to healthcare provided by the Refugee Act. She writes:

> …the transient nature of migration as well as the fact that forced migrants may have recently left countries where social services were disrupted, and so where little or no health care was available, makes migrants susceptible to compromised immunity…foreign migrants in South Africa are self-settled and live among South Africans. Living in close proximity to anyone who lives in a deteriorating urban environment and often unfavourable socio-economic conditions is a health risk (Pursell 2005; 11).

However, migration in some cases has improved the well-being and health of migrants. Health is often improved for women from poor countries who move to regions where they may be able to manage their fertility and sexual reproductive health (The Lancet 2006: 1039).

Roux and van Tonder (2006) discuss findings of the South African Migration and Health Survey, which aimed at providing a reasonably comprehensive picture of the

interrelationship between migration and health in South Africa, and examines the different health outcomes by migration status as well as the factors that affect migrant health. Their study shows that it is unclear what role access to healthcare facilities in the proposed area of destination plays in attracting migrants to particular areas, or to understand what role health information plays in migration decision-making. What was clear is that less than ½ a percent moved to improve their access to social and public (including health) services. Less than 60% of migrants obtained information before moving regarding health and public services in the destination areas. However, the two scholars argue that migrants who make better-planned moves e.g. accepting a job transfer or assignment, exploring better economic, accommodation and educational opportunities, or when attracted to the lifestyle a destination area seems to offer, show that they are more likely to obtain such information before moving (Roux and van Tonder 2006: 142). Refugees had the least likelihood of obtaining information regarding health and public services before departure.

In sum, this section has outlined the state of research on migration and health in general, and issues of access, discrimination, migration/health linkages as well as experiences of migrants in South Africa in particular. These studies provide the premise upon which this study sets off and tries to contribute to the existing gaps, especially the need for more studies concerned with south-south migration health issues. However, the study is not only informed and shaped by the works cited in the literature review but it also applies some theoretical models on health-seeking behaviour.

2.4 Factors influencing healthcare utilisation by migrants

2.4.1 Socio-economic and legal factors

There are several socio-economic and legal factors that influence the utilisation of healthcare services by migrants in the host country. In the literature significant attention has been given to barriers that migrants face in accessing health care. These barriers are argued to explain why migrants resort to certain forms of medical treatment or why they underutilize formal channels. Barriers to healthcare access fall

in two categories namely, financial and non-financial barriers. Guendelman (1985) argues that poverty, fear of deportation, discrimination, language difficulties, lack of insurance coverage have been identified as barriers to achieving access to the health system by Mexican immigrants. These barriers also appear to explain why those adults who enter the medical system use a variety of health settings which are not limited to hospital care. Treatment of non-acute illness seems to be sought in clinics and to a lesser extent in private physicians' offices. Chavez (cited by Guendelman 1985) has noted that women especially prefer clinics because they often offer sliding fee scales which can be paid in cash or in instalments. Self-medication, using over-the-counter drugs, has been frequently reported by Mexican females. Several studies show that undocumented immigrants are as equally good or better at meeting their financial obligations than other indigents. They often prefer to pay cash since it avoids questions on their status. Despite this track record, American health agencies, and hospitals in particular, often complain of a financial drain caused by treating the undocumented migrants (Guendelman 1985; 494-495).

Some studies have discussed issues relating to documentation or legality status as a barrier of access to healthcare among undocumented migrants. Moore (1986) asks a pertinent question on how legal status affects the undocumented immigrant's access to health care. He argues that due to the wide variety of laws and regulations that affect the undocumented population, as well as the politically sensitive nature of the issues, there is much misinformation and lack of communication among and between health-care providers and patients on the rights of the undocumented to health care. To this matter he concludes “thus the undocumented patient suffers from both real and imagined legal uncertainty” (1986: 66). Marshall et al (2005: 917) have shown that migration status is a factor that contributes to the vulnerability of some Latino immigrants, especially the undocumented in the United States who experience legal difficulties due to lack of documentation, which may make it difficult for them to find jobs and achieve economic stability.

Related to the issue of legality status is therefore fear of deportation which makes undocumented migrants remain hidden from accessing their basic rights to health as provided for by the law. It is argued that undocumented migrants experience the same barriers as documented migrants and non-migrants in a given country but they have

one difference in that undocumented migrants experience one additional problem—"a sometimes crippling fear of deportation" (Moore 1986; 69. In a nutshell McGuire and Georges sum up that as a "source of prolonged stress, undocumentedness can exacerbate health risks because of other variables such as affordability, accessibility, acceptability, knowledge, cultural views and practices, and willingness to seek care (2003; 190).

Young, *et* al. cited by Evans (1987) provide a wider cultural perspective to the problems of providing health care to immigrant populations. The barriers to health care were largely language related. It is also important to note that migrants bring their own explanatory models to explain disease and attitudes towards practices such as testing, which could negatively affect intervention programmes. In Molapo's study of Basotho migrants, she describes the cultural explanations and perceptions of illness, disease and well-being as they are understood by the workers. For example, blood is viewed as the source of life and if one does not have "healthy blood" they are constantly sick and will eventually die. As such clinical withdrawal of blood for testing is a sensitive issue and creates suspicion that "blood may become contaminated while it is in the laboratory and that this in turn will make them sick" (Molapo 1995: 97).

2.4.2 Models of health-seeking behaviour

There are several models of health-seeking behaviour that can be used to understand and contextualise the factors that influence health care services utilisation by migrants. One such model is the health care utilisation model adapted from Andersen.

(a) The Health Care Utilisation Model: The socio-behavioural or Andersen Model (cited by Hausmann-Muela et al 2003) groups in a logic sequence three categories of factors (predisposing, enabling and need factors) which can influence health behaviour. Initially the model was developed to investigate the use of biomedical health services but has been adopted in the probing of other health care sectors such as traditional medicine and domestic treatments. The diagram below illustrates the model:

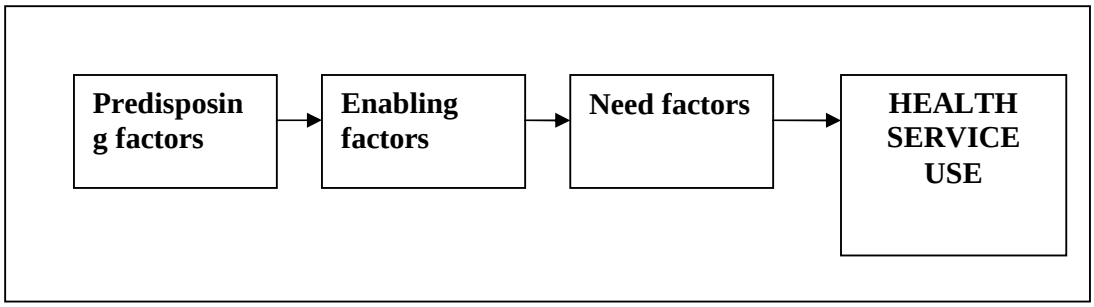


Figure 1: The Health Care Utilisation Model

Source: Hausmann-Muela et al 2003: 14)

Examples of predisposing factors include: age, gender, religion, global health assessment, prior experiences with illness, formal education, general attitudes towards health services, knowledge about the illness etc (Weller *et* al cited by Hausmann-Muela et al 2003: 12). Enabling factors incorporate: availability of services, financial resources to purchase services, health insurance, social network support etc. Need factors comprise, perception of severity; total number of sick days for a reported illness; total number of days in bed; days missed from work or school; help from outside for caring etc. Another group of factors would be the actual treatment actions such as home remedies (herbal or pharmaceuticals), pharmacy, over the counter drugs from shops, injectionists, traditional healers, private medical facilities, public health services etc. (Hausmann-Muela et al 2003: 13).

In a sense this model specifically looks at treatment selection in both material and structural factors, which are barely taken into consideration in the psychology models. Weller et al (cited in Hausmann et al 2003) emphasised its particular use for working with statistical data on actual cases. In addition to the predisposing factors, referring to the structure of the health care system and its link to a country's social and political macro-system. This is a valuable extension as it puts emphasis on the link of health-seeking behaviour with structural levels within a macro-political and economic context. However, the model has been critiqued for omitting the 'need factors' which are central for understanding health-seeking behaviour (Weller et al cited in Hausmann 2003: 13).

Kroeger 1983 went on to elaborate the Andersen model by proposing the following framework:

Interrelated explanatory variables, all of which are affected by perceived morbidity;

- An individual's traits or disposing factors: age, sex, marital status, status in the household, household size, ethnic group, degree of cultural adaptation, formal education, occupation, assets (land, livestock, cash, income), social network interactions.
- Characteristics of the disorder and their perception: chronic or acute, severe or trivial, aetiological model, expected benefits or treatment (modern versus traditional), psychosomatic versus somatic disorders.
- Characteristics of the service (health service system factors and enabling factors): accessibility, appeal (opinions and attitudes towards traditional and modern healers), quality, acceptability, communication, costs.

The interaction of these factors guide the election of health care resources (dependent variables).

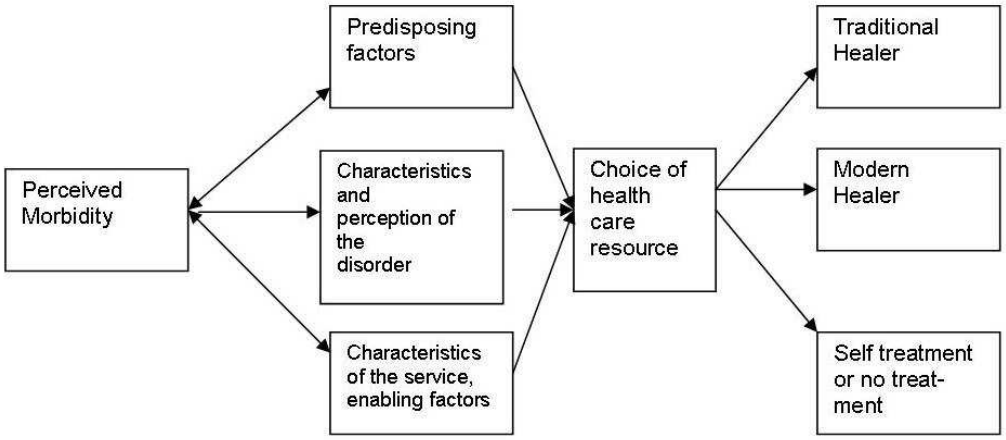


Figure 2: Kroeger's Model 1983
Source: Hausmann-Muela et al 2003: 14)

(b) The political economy of health approach: Concerned with the macro societal determinants impacting health, the political economy of health approach (PEHA) places its attention on the economic and political structures lying at the base of social production of morbidity or the rate of disease incidence in population group. Morgan (cited by Nunez 2008) defines the PEHA as a "micro-analytic, critical, and historical perspective for analyzing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political and economic relations within world economic system." The expansion of the

capitalist system is recognised by the PEHA as the most significant, transcending contemporary process and increasingly shaping and reshaping social life. Moreover macro-economic transformations create economic and social exclusion of large social groups, manifested in their marginal access to economic and social resources, security, housing and health (in Nunez 2008: 44).

In Nunez (2008)' study, the economic migration of Peruvian workers into Chile is a consequence of the expansion of capitalism and the emergence of new forms of labour such as labour provided by transnational migrant workers. Such workers' increasing vulnerability is the result of the weakening of the laws and structures that protect workers well-being (e.g. labour legislation, social security provision) and now labour-flexible schemes in time with the changing needs of the capitalist system for expansion. These factors have increased the previous work/economic conditions of migrant workers and ultimately impact upon their health (Nunez 2008: 45). However, PEHA has shortcomings when related to anthropological analysis. Its emphasis on societal macro forces has resulted in a tendency to 'depersonalise the subject matter and the content of medical anthropology by focussing on the analysis of social systems and things, and by neglecting the particular, the subjective context of illness, suffering and healing as lived events and experiences. This is equally interesting in the case of Zimbabwean migrants who flee economic hardships in their country to seek better economic opportunities in South Africa, because their biggest asset as alluded to in the migration health segment in this chapter, are their healthy bodies that enable them to work. This theoretical assertion contests the arguments that migrants come to South Africa to access better off healthcare services.

2.5 Conclusion

It is upon this framework that this study will discuss the findings presented in the study and attempt to answer the research questions that have been mentioned in the introductory chapter. The following chapter will now delve into a discussion of the methodology used in the study.

CHAPTER 3: METHODOLOGY

3.0 Introduction

This chapter discusses the methodology that was used to explore the patterns of healthcare services utilisation by Zimbabwean migrants living in South Africa. By its nature as a Masters Research report, the study is small scale. It involved the systematic collection and presentation of data to give a clear picture of a particular situation and in this situation, health care services utilization by a particular migrant group in South Africa.

3.1 Research Design

The study's main objective was to explore the factors which determine the utilization of public health facilities by Zimbabwean migrants in Johannesburg. In so doing, it sought to describe and also explain the different patterns of behaviour in relation to the utilization of health care services. The research design is an exploratory descriptive study of the utilisation of health care services by Zimbabwean migrants in South Africa. Two data gathering techniques were used in the study namely, the analysis of secondary quantitative data from a survey conducted by the Forced Migration Studies Programme (RENEWAL) and an in-depth follow up qualitative study of four Zimbabwean migrants who had recent health-seeking experiences in Johannesburg South Africa.

3.2 Secondary Data Analysis

The RENEWAL's central primary data collection tool for the multi-site study was a quantitative household survey. This was modified for the Johannesburg context. The survey was conducted across a range of housing types in Johannesburg. So it was divided into two areas: (1) urban formal areas of the dense inner-city and (2) an urban informal settlement. A total of 487 household survey questionnaires were completed

and are used in the analysis. This provided information on 1,533 individuals. The table below illustrates the distribution across the four suburbs:

Table 4: Distribution of respondents according to suburb

Surburb	No. of Respondents
Sol Plaatjies	195
Berea	101
Hillbrow	90
Jeppestown	101
Total	**487**

The three inner-city suburbs shown in Table 5 above were purposively selected from the inner-city; basing on prior knowledge of previous studies by the Forced Migration Studies Programme which established that these where areas that cross-border migrants live. In the selection of the survey suburbs over-studied suburbs such as Yeoville that are known to have a large cross-border migrant population were not selected. Copies of all Statistics South Africa (Stats SA) 'Enumerator Areas' (EAs) for each of the three suburbs were sourced for the purposes of selecting research sites for the study. Stats SA uses EAs in the census of 2002 (Vearey et al 2008: 54). Use of the Stats SA EAs enabled comparisons to be made to census data and the EAs were developed to each contained a similar number of dwellings of up to 300. Three EAs were randomly selected from each suburb. This was done by printing all EAs for each suburb and blindly selecting three per suburb. An equal number of households were selected from each building or block within the EA.

In areas with high density such as Hillbrow and Berea information on the number of flats per building were obtained in advance by field researchers who approached the caretakers or owners of the flat. Doing this enabled the sampling of households to be appropriately weighted depending on building size. For example in apartment blocks, households would be evenly distributed across all levels. The sampling frame involved selection of the first house in the north-west corner of each cluster as the starting point. For the second household the fieldworker moved clockwise in the cluster and selected the third house. For each EA, 33 households were selected (Vearey et al 2008).

The survey comprised both cross-border and internal migrant households in the sample population. In addition, a group of South African respondents who reported to have ‘always lived in Johannesburg’ were included for comparative purposes. It turned out that 65% (n=292) of respondents were internal migrants, 25% (n=146) of respondents were international migrants and 10% (n=44) of respondents had always lived in Johannesburg. Of interest to the present study was the fact that, unexpectedly out of 146 international migrants, Zimbabwean migrant respondents numbered 118 (80.8%). The data from the survey therefore provided a basis for analysing healthcare utilisation patterns of Zimbabwean migrants who participated.

The survey made it possible to quantify the distribution of certain variables in the study population. For example in this case, using the Zimbabwean sub group of respondents, it was possible to quantify the number of respondents who stated that their income or legal status prohibits them from utilizing health care services. A survey can also reveal interesting associations between variables, for instance between seeking treatment at a hospital and socio-economic status, gender and education (Patton 1990).

The survey results were grouped together and analysed through statistical package software JMP 5.1. It is important to note that the since the researcher was concerned with the dimension of Zimbabwean respondents, the analysis was based mainly on extracting relevant data to address the research questions of the report. This software proved to be a useful tool in establishing the descriptive statistics on patterns of healthcare utilisation, and important information on socio-demographic characteristics of the respondents, among other things as they related to Zimbabwean respondents. In some cases comparisons were made with data on other groups of respondents.

3.3 In-depth Interviews

In order to get in-depth explanations and experiences of the respondents, four depth interviews were conducted by the author. The open-ended responses allowed the researcher to understand the world as seen by the respondents. Moreover the researcher managed to capture the points of view of respondents “without

predetermining those points of view through prior selection of questionnaire categories" as in the quantitative survey (Patton 1990; 24). The open-ended questions solicited answers that were overlooked by the closed questions especially the third research question which sought to establish the actual experiences of migrants who had tried to access health care. The open-ended questions were also essential generally in trying to establish the experiences of both undocumented and documented migrants who utilize healthcare services and the alternatives they have at their disposal.

The recruitment of in-depth interview participants was done through opportunistic and snowball techniques, by first identifying Zimbabweans likely to have significant experience of seeking healthcare treatment at a South African hospital or other service provider and asking for referral to other Zimbabwean migrants known to the respondents who were in similar situations.

Code	Age	Gender	Education	Occupation	Marital Status	Legality Status
IDI1	33	Male	High school	Self-employed	Widower	Undocumented
IDI2	28	Female	Diploma	Accounts Clerk	Married	Undocumented
IDI3	37	Male	High school drop out	Self-employed	Living with partner	SA ID
IDI4	24	Female	Nursing Diploma	Waitress	Married	Asylum

Table 5: Socio-demographic characteristics of recruited Zimbabwean respondents (qualitative)

NB: IDI is code for in-depth interview

The open-ended questionnaire was developed in the light of the crucial question areas to be addressed. It was basically a schedule of guideline questions. Due to time limitations, only one attempt was made to field test it. The final questionnaire is attached in appendix 2.

Data analysis was done through selective coding by grouping responses, conceptualizing them, categorically labelling them, identifying their properties and establishing relationships between them. These codes were created by using themes

from the research questions and the list of codes drawn upon closer scrutiny of field notes. Coding is necessary because it ensures easier retrieval and organization of chunks of text in order to categorize it according to certain themes (Welman, Kruger and Mitchell 2001; 214). Direct quotations from the interviews are essential for revealing respondents' depth of emotion, the ways they have organized their world, their thoughts about what is happening, their experiences, and their perceptions (Patton 1990; 24). Hence some direct quotations will be cited verbatim in the report in order to illustrate respondents' experiences. One such example is a box which narrates a story about a respondent's experiences.

3. 4 Ethical Issues

Considering the sensitivity of this topic which could cause fear of moral judgement or shame to the respondent, the researcher complied with the ethics requirements involved. Ethical approval for the RENEWAL study was obtained from the University of the Witwatersrand Medical Research Ethics Committee (protocol number: M071125, 2008). The author was given permission to use the data from the Principal Investigators of the RENEWAL study for academic purposes.

Although none of the respondents of the qualitative in-depth study raised questions which I could not address immediately, I was prepared to make appropriate referrals to guide the respondent especially to relevant service providers. Since some of the respondents interviewed in the study are in the country 'illegally' I took precautions to ensure that confidence among them was gained and that there were no risks of exposing them. To warrant that the research did not cause participants any form of harm (moral, physical, emotional), careful steps were taken in the guidelines for interviews and questionnaire design to minimize potential discomfort to informants. I devoted a period of time before the interview to inform and explain the purpose of the research and then to seek consent of the respondents. Their names, addresses, and phone numbers were not recorded on the interview response to ensure their anonymity. In line with research ethics, the researcher ensured that only the population selected for the study were those to whom the research question applied (Wassenaar 2008; 8). The interview with female respondents was conducted in a

suitable atmosphere, on the balcony of her residence, in the open where passers-by or neighbours might not become suspicious of the researcher. Her husband gave prior consent but he was unwilling to participate.

In sum the chapter has demonstrated how the researcher gathered the data used in the writing of this report. It has outlined the research design, data collection techniques and ethical issues that were involved. The chapter that ensues will present the findings.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter presents the findings from the RENEWAL quantitative survey, particularly the healthcare services utilisation patterns of Zimbabwean migrants who participated in the survey. It basically comprises a sub sample from the data that have been extracted from the RENEWAL data which looked at internal South African migrants, international migrants and South Africans who have always lived in Johannesburg. The findings of the in-depth interviews filled gaps from the RENEWAL data. Bearing in mind the research questions, the data is presented under the following sub-headings; socio-demographic characteristics of respondents, factors influencing the utilization of health care services and their experiences with accessing healthcare. The chapter tries to answer these empirical research questions, while an attempt is made to interpret the findings within the theoretical framework of the research report.

4. 2 Socio-demographic characteristics of respondents

In the RENEWAL household survey, a total of 489 individuals were interviewed, providing information on 1533 individuals. Forty percent of households were interviewed in the informal settlement (Sol Plaatjies) and sixty percent from three suburbs of the innercity (Berea, Hillbrow and Jeppestown). The survey respondents were stratified into one of three migratory categories; (1) South African internal migrants (n=292, 60%); (2) cross-border migrants (n=146, 30%); and (3) a control group of South Africans who have always lived in Johannesburg (n=44, 10%). Of the 146 cross-border migrants 118 (80.8%) of them were of Zimbabwean nationality (55.1% male and 44.9% females). The table below shows the distribution of the Zimbabwean migrants among the three suburbs studied:

SURBURB	FREQUENCY	PERCENTAGE
Sol Plaatjies	9	8
Berea	43	36
Hillbrow	55	47
Jeppestown	11	9
Total	118	100

Table 6: Place of residence of Zimbabweans in South Africa

Table 7 above shows that the majority of Zimbabwean respondents came from Hillbrow (55; 46.6 %) and Berea (43; 36.44%). This is quite understandable in the light of other research findings such as the Wits-Tufts Survey showed that migrants tend to live in the inner-city areas of Johannesburg[5] (see Jacobsen and Landau 2003). However, since it was beyond the scope of the study, it was not enquired as to why most of the Zimbabwean migrants particularly from Matabeleland provinces of Zimbabwe constitute a significant proportion of respondents who live in Hillbrow and Berea. As a result of random sampling, it turned out that the majority of international migrant respondents were Zimbabweans, whom were largely from Matabeleland.

The ages of Zimbabwean respondents varied between 19 and 78 years, of which the majority fell within the young adult age groups as indicated in Figure 3 below. Only three respondents out of the 118 are above fifty years of age, of which one is 78 years old. More than half of the respondents are between 20 and 30 years old. This is quite an interesting scenario because international migrants tend to be of a certain age group, mostly young people. This can also be contextualised in the light of studies that have tried to examine the profile of Zimbabwean migrants in South Africa. One such study by Landau (2008) reasoned that when it comes to the Zimbabwean population of an estimated 12.3 million people, about 7.6 million constitute the economically active population (16-64 years) of which 3.6 million are young adult males. Thus one could concur that it is perhaps the latter group who are likely to migrate from Zimbabwe in search of opportunities (Landau 2008: 9). A diagram showing their age groups is illustrated in the figure 3 below:

5 The survey was conducted in Berea, Bertrams, Bezuidenhout Valley, Fordsburg, Mayfair, Rosettenville and Yeoville.

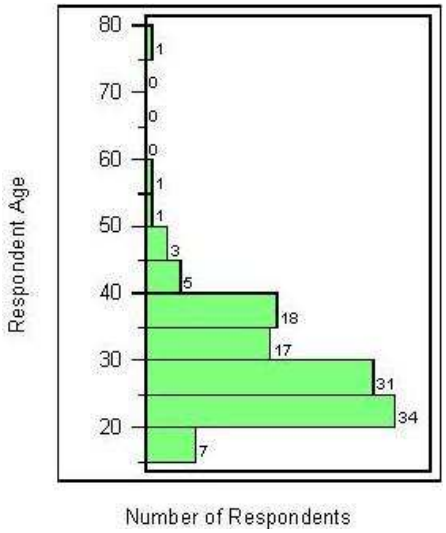


Figure 3: Age distribution of respondents

In terms of areas of origin within Zimbabwe, most of the respondents are likely to come from Matabeleland namely; Bulawayo, Plumtree, Gwanda, Tsholotsho, Esigodhini and Nkayi. By inference with their areas of origin they are also most likely to be of Ndebele origin.

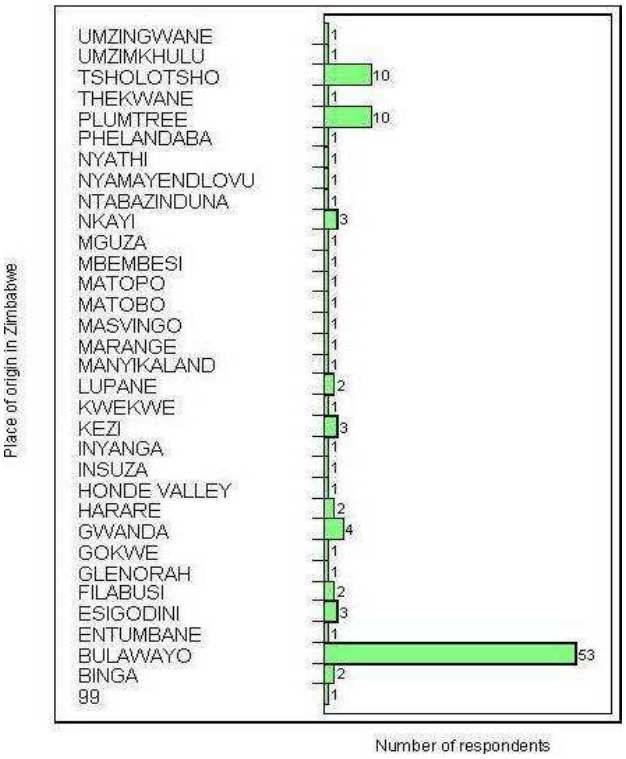


Figure 4: Figure: Distribution by place of origin in Zimbabwe

The presence of more Zimbabwean respondents from Matabeleland than any other areas of Zimbabwe could be attributed to several factors, based on the researcher's assumptions and inference; Matabeleland has been comparatively marginalised in terms of development and employment creation opportunities even during the time the Zimbabwean economy was performing well; also the trend of migration as indicated in the background section, had already begun resulting from the Gurukurahundi persecutions in the 1980s. However these are limited explanations when one tries to understand which one constitutes the larger population in South Africa between the two ethnic groups from Zimbabwe. But if one infers to what is known generally about the way migrants tend to cluster and settle in certain areas and then their kith and kin who migrate later also come to join them, then maybe this can explain why their dominance in Hillbrow and Berea. Perhaps in other areas of Johannesburg and South Africa at large, Shona-speaking migrants would tend to dominate in higher numbers, where their predecessors settled upon arrival.

Another important aspect in appreciating the socio-demographic characteristics of the respondents interviewed in the survey is their length of stay in South Africa. The overall assessment is that the respondents tended to be fairly recent arrivals having lived between 0 and 3 years in South Africa. Over fifty percent (62 out of 118) had lived in South Africa for less than three years, and almost all (102 out of 118) had lived in South Africa for less than ten years. Only one respondent has lived for over fourteen years.

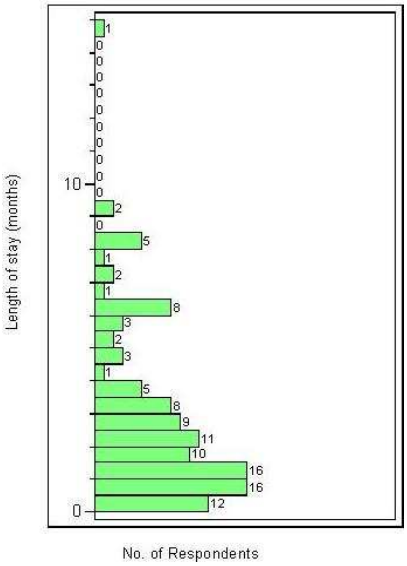


Figure 5: Length of stay

The length of stay is an important variable because it plays a significant role in determining the (non)usage of healthcare facilities or the status of a migrant's health after arriving in the host country. An understanding of its implications on the results will be unpacked later in the discussion.

4.3 Factors influencing the utilization of health care services

There are several factors that impact on healthcare utilisation by migrants and therefore this report categorises each of the factors in the light of the existing findings. As has been highlighted earlier in the report, there are situational and attitudinal variables associated with health utilisation patterns. Situational variables comprise; length of residence, household size, age, marital status, gender, education in home country and South Africa, religion, language proficiency/problems, income, employment and medical assistance, among others. Attitudinal variables consist of perceived health status, acculturation and perceived self-sufficiency. However, the quantitative data do not include all of these variables. Some of them have already been discussed in the preceding segment and so in this segment I explore the health status of respondents, their illness episodes/illness incidences and nature of illness, whether they sought treatment, and their choice of healthcare service provider drawing on the variables available.

(i) Self-reported health-status

One of the determinant factors of healthcare utilisation is health status. Thus the respondents were asked to indicate their self-reported health status at the time. A large proportion of the 118 reported their health status to be good (74 %) and very good (10 %). A few (14%) reported average health status while 2% described their health status as poor. It can be noted however that considering that respondents were asked to report on the health-seeking behaviour of other members of the household, there is potential for bias since people do not often declare their health problems, even to members of the same household.

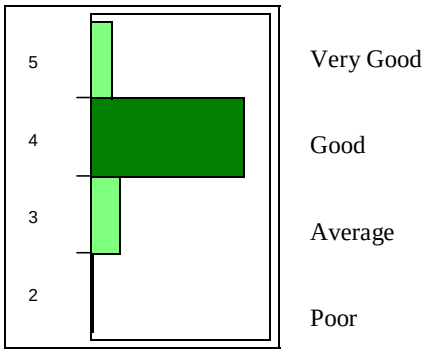


Figure 6: Self-reported Health Status

However, a reasonably large number (58%) did not engage themselves in any health-conscious activities to maintain their health, they happened to be just healthy.

Activity	Count	%
Nothing	68	58
Eat well	20	17
Exercise	13	11
Go to doctor for check ups	10	9
Don't stress	3	3
Pray	2	2
Other	1	1
Total	117	100

Table 7: What do you do to keep yourself healthy?

Eating well was considered to also be an important way to keep healthy by at least 17% of the respondents and only 9% actually go to the doctor for check-ups. Exercising is relatively important for 11% of the respondents whilst at least two of the respondents pray to God for good health.

***(ii) Illness Episode**:*

Respondents were asked to recall any illness episode within the past twelve months or more. The target for the survey was to probe further those respondents who had been ill within the past twelve month period. A large number out of the total respondents (118 Zimbabweans) had not experienced sickness or illness in the said

period. Only a small proportion reported themselves or any members of their household to have had an illness experience within the past twelve or more months.

Level	Count	Prob %
This week	1	1
This month	6	5
Last month	7	6
Two months ago	5	4
3-6 months ago	4	3
7-12 months ago	1	1
More than 12 months ago	16	14
I am never sick/no-one in this household is ever sick	76	64
A member of this household is sick all the time	1	1
Other	1	1
Total	118	100

Table 8: Reported illness episodes

Out of the 118 respondents only 41 reported an illness episode in the last twelve or more months. The majority, 76 (64.4%) reported that they had never been sick at all. This is the same situation for the overall responses to this question whereby the majority 265 (55%) reported that they had never been ill nor had anyone in their current household within the past twelve or more months. Only 1 % of the Zimbabwean migrants admitted that a member of the household was sick all the time. In addition one respondent or member of the household was ill at the time of the interview and another 1% reported sickness between seven to twelve months ago. This study was concerned with those people who had been ill in the last twelve months i.e. 25. Therefore part of the results that follow are based on that smaller subset of respondents.

It was also important to ask all the respondents if at any time they ever suffered from illnesses such as tuberculosis. Thus among the respondents asked if any of the respondents had suffered tuberculosis in their lifetime, the majority 117 out of 118 said no.

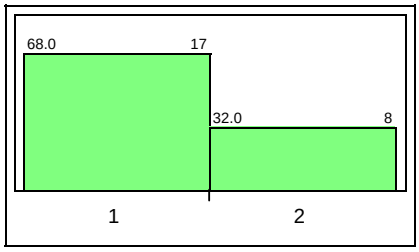
There are different types of illnesses reported among the twenty-five respondents who had been ill in the last twelve months. The table below illustrates these:

Illness	Male	Female	Frequency	Percentage %
1.Coughing	1	2	3	12
2.Flu	2	2	4	16
4 Diarrhoea	0	1	1	4
5. Weakness	3	1	4	16
6. Emergency	1	1	2	8
11. Body pains	1	0	1	4
12. Cervical/vaginal	0	2	2	8
13. Dental	1	0	1	4
16. Injury	2	0	2	8
17. Other	1	4	5	20
Total	**13**	**12**	**25**	**100**

Table 9: Nature of healthcare problem

The major illnesses reported by the respondents were coughing (12%), flu (16%), and weakness (16%) and others (20%) unspecified.

In terms of seeking remedy the majority, 17 out of 25 (68%) sought help for their illnesses while the remaining 8 (32%) did not seek treatment, care or advice from a healthcare service provider.



Note: 1=Yes and 2=No

Figure 7: Did they seek treatment?

Among the eight who did not consult a healthcare service provider, five of them already had medicine with them; one consulted a relative, the other did nothing and another was provided medicine by the employer:

Level	Count

Consulted a relative	1
I already had medicine	5
Employer provided medicine	1
Nothing	1
Total	8

Table 10: Did not consult a healthcare service provider

The decision to seek treatment for an illness is, according to the literature, largely determined by 'need factors' such as those mentioned by the Weller et al 1997 healthcare utilisation model (cited by Hausmann-Muela et al 2003), which argues that the patient or ill person is likely to consider their perception of severity, total number of sick days for the reported illness, total number of days in bed, days missed from work or school, help from outside for caring, among other things. Although these factors were not probed in detail among the respondents, there is an indication that among the 17 who sought treatment, probably a large number considered their 'levels of need' for treatment. Added to this the treatment actions of the remaining eight also point out to their perceptions of severity or need on the one hand, and also to their preferences on treatment action on the other.

(iii) Choice of service provider:

In most cases respondents indicated their choice of healthcare service provider and this was mostly the facility in closest proximity to their dwelling.

Government healthcare facilities were relatively popular as the first place of consultation among the respondents who sought help:

	Frequency	**Percent %**
Government Clinic	5	29
Government Hospital	6	35
Private Clinic	3	18
Private Doctor	2	12
Pharmacy	1	6
Other	0	0
Total	17	100%

Table 11: Which place did you go first to seek medical advice?

The reasons for the selection of facility were attributed to nearness of the health facility to the respondent's place of residence. Only one respondent chose the healthcare facility because "it treats anyone regardless of their nationality".

Reasons for choosing facility	Frequency	Percentage %
It is nearest	8	53.3
Good services/friendly	2	13.3
Referred by friend/family/neighbour	3	20
Will treat even if not South African	1	6.6
Other	1	6.6
Total	15	100%

Table 12: Reasons for choosing healthcare facility

Despite legal status not being reflected as a reason impacting on choice of facility, one of the respondents in the in-depth interviews however, blames her legal status for limiting her choices of healthcare service:

> If only we had the right papers, my husband and I would have been contributing towards medical aid. That way we would have gone to a decent private care hospital like we always did back home. I felt much degraded having to go to a public hospital where it is free and the nurses treat you badly. A friend of ours referred us to a public clinic where I delivered our baby. It was such a nasty experience, if my husband had not offered transport to one of the midwives at the clinic on that night, I would have faced birth complications. No one was there to induce me and I was getting restless in labour. (IDI 2, Female Zimbabwean, 2009)

From the survey data it appears from the small sample that migrants are able to negotiate and easily access health care services that are owned by the government. Also the migrants' actions concur with the explanations of the Kroeger model which argues among other things that the characteristics of the service (or health system factors and enabling factors) influence one to seek treatment or to choose that particular service. In this case, from the survey data, the nearness of the healthcare facility, quality of service and the fact that the hospital does not discriminate against non-nationals are important factors indicated in the study.

4.4 Experiences with accessing healthcare

The questions asked in the survey probed the different experiences that respondents and members of their household faced in trying to access healthcare services. This included asking them about their mode of transport to get to the hospital or clinic; whether they were denied or granted treatment; asking them about the quality of treatment; and how much they paid if they were asked to pay etc.

The respondents were asked to rate the standard of first healthcare facility which they had first consulted. Most of the responses indicate satisfaction with standards of the facilities as indicated in the figure below:

Level	Count	Percentage %
Average	5	29
Good	10	59
Very Good	2	12
Total	17	100

Table 13: Standard rating of 1st health service provider consulted

Added to this standard rating, almost all respondents 16 out of 17 indicated that they received the treatment that they wanted. They were satisfied by the quality of treatment they received. The only respondent who felt the treatment was not satisfactory indicated that this was due to the shortage of medicine within the healthcare facility and did nothing to rectify the situation. However, in one of the qualitative interviews, a respondent stated that the nurses were 'rough' when they were dressing her wound, hurling insults at her:

> First they refused to treat me after I explained that I had been stabbed during a scuffle with thieves who stole my cellphone. From then on, the nurse who was attending to me began to pull tightly my bandage unnecessarily and uttering some harsh words in Sotho. As a nurse also by training I could tell that this nurse was just trying to "fix me", because I was speaking English to them. Part of me was grateful that at

> least I was not denied treatment outright, but I was hurting with the way I was being treated. Back home patients used to also complain that we treated them badly, but I think they have never been to South African hospitals, we treated them better. (IDI 4 Female Zimbabwean, January 2009).

In this case the respondent received treatment but she felt insulted even though she says that she was grateful that the nurses treated her.

Regarding transport, the majority of the respondents did not have to drive or catch a bus to a healthcare centre. As shown in the table below, the nearness of the healthcare centre made it possible for the majority of patients to walk, whilst others used different modes of transport:

Mode	Count
Walked	11
Bus	1
Metred taxi	1
Train	1
I got a ride with someone	1
Ambulance	1
Other	-
Total	16

Table 14: Mode of transport to healthcare centre

Regarding hospital fee charges, those who were asked to pay for hospital fees are no less likely to be much more than those who received free treatment (yes=8 and no=9).

Among those who were treated at the different healthcare centres, a slightly higher number needed medication (yes=9 and no=7). Out of those nine patients, five of them obtained their medication from a clinic, while the other four obtained their medicine from the hospital—all of which are government institutions. Among the nine, only two of them were asked to pay for the medication. Between the two respondents who paid for healthcare one of them paid R350 and the other paid R600. The willingness of the Zimbabwean migrants in the survey to choose treatment is also explained by

the health-seeking behaviour models. The Andersen Model (cited by Hausmann-Muela et al 2003: 13) lists some of the treatment actions that can be selected such as home remedies (herbal or pharmaceuticals), pharmacy, over the counter drugs from shops, injectionists, traditional healers, private medical facilities, public health services etc.

4. 5 Alternative Sources of healthcare

Generally speaking, the majority of the 118 Zimbabwean migrants interviewed in this study indicate that they do not have healthcare plans or safety nets in the event of illness. They said they would not know what to do. It seems their being in South Africa strongly depends on being healthy and in the event of poor health they face uncertainties:

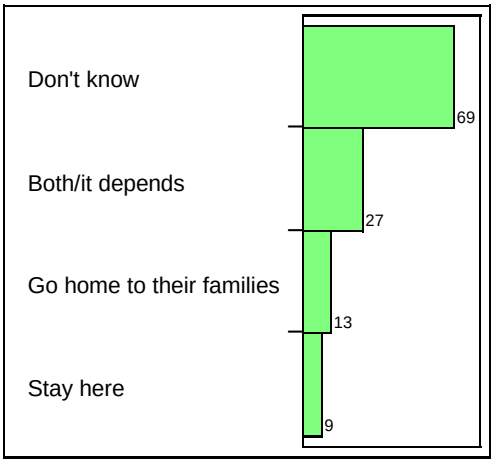


Figure 8: What do people here do if they get sick?

As it stands, the number of migrants who already have plans of returning home in the event of illness (13) is not as significant as those who have no idea what they would do (69). Perhaps the 27, who stated that it depends on circumstances, meant they would weigh the seriousness of the disease so as to make a decision on going back or staying in South Africa. In the event that they decided to stay in South Africa, most of the respondents (n=36) would expect to be taken care of by members of their household residing here in South Africa:

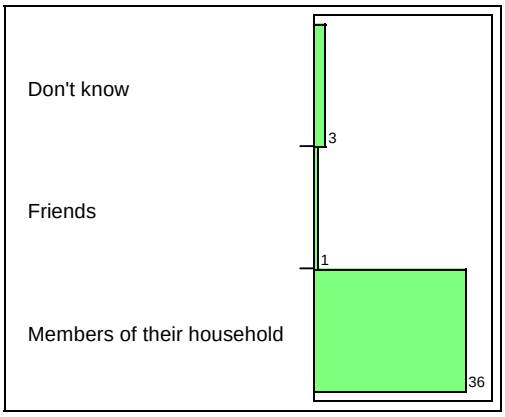


Figure 9: Who could take care of them in South Africa?

The assumption that the respondents would be taken care of by household members in South Africa when they fall ill shows that as a first resort, depending on the illness severity, respondents would prefer to stay in South Africa until their situation declines.

The response to the question of returning home in the event of chronic illness was overwhelming as most respondents 68% indicated that they would not stay in South Africa. The link between health and the ability to work was ascertained in this question as the responses showed that migrants need to be healthy in order to stay in the country.

Response	Count	Percentage %
Stay	38	32.48
Go home	79	67.52
Total	117	100

Table 15: If you were sick & unable to work what would you do?

An interesting dimension to the link between migration and health indicated in the responses was that very few of the respondents ever hosted a visitor from home who came to seek healthcare treatment:

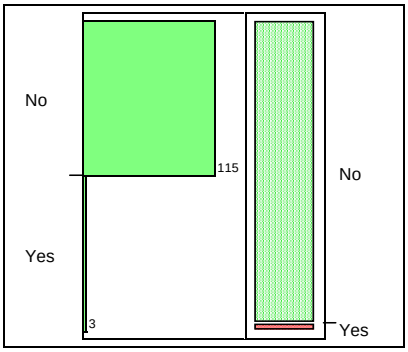


Figure 10: Ever hosted a sick relative from home?

Very few of the migrants hosted a sick relative from home mostly because Johannesburg is a place of work and therefore an area where the healthy come and work to support their families back home (yes=3 and no=115).

The issue of returning home when chronically ill was explored in one of the qualitative interviews that were held as a follow-up to the findings of the survey. In Box 1 below is an account of a respondent, Marshall who had to return home in order to leave his spouse at home in the care of her relatives because of her ill-health but unfortunately she passed away on the way to Zimbabwe.

Box 1:Returning home when sick

Marshall and his wife Mucha* came to South Africa in October 2004 in search of employment. Marshall had acquired motor vehicle repairing skills from his father and had been working in Zimbabwe as an unqualified mechanic for seven years. His wife Mucha was a hairdresser. They lived on the East Rand in Germiston upon arrival in South Africa. For the couple employment was difficult to find, but at least for Mucha she easily found opportunities to work on a part-time basis in hair salons. During the evenings she would work on her clients' hair to supplement her income. Her husband spent much of his time job hunting with little or no success, at one time he had a three month contract to work for a garage but after the contract he was underpaid for no apparent reason. Marshall left the garage as a disgruntled man and often drowned his sorrows in alcohol. Six months after their arrival in South Africa the couple had become undocumented because their passports had expired. For Marshall this was equally a challenge because he could not speak any South African languages as his wife did and he could not easily walk around Johannesburg or Germiston to search for employment. This added to his frustrations with job seeking and even though his wife kept on encouraging him he says he had learnt to accept that he would never find employment in South Africa and that his wife had become the breadwinner. This last feeling complicated relations between the couple because Marshall could not make financial decisions in the home, especially for luxuries such as alcohol. He confessed that much of the time when they argued it was because he had pinched his wife's money only to buy a drink. His wife would fume at his drinking habits which were a strain on the family's meagre income. They had to support their child whom they had left in Zimbabwe.

Three years later in 2007 life went on for Marshall and his wife until one day she complained of a headache. Marshall claims that his wife had always suffered headaches more like migraines but had never been sick enough to become bed-ridden. At the time when Mucha complained about severe headaches the couple did not envisage it was a sign of trouble. Gradually Mucha began to deteriorate and this posed problems for the couple in terms of income generation and basic living conditions. Marsall had to start seriously searching for employment but he had to also take care of his sick wife. He learnt from his friends that even though they were undocumented they could seek health care from the public hospital in Germsiton which was more affordable. The hospital nursing staff were accommodating and all they had to produce was Mucha's passport despite the expired visa.

Sadly after one and half months in hospital, the doctor advised Marshall to take his wife home because her conditioned had deteriorated to such an extent that she could not speak or eat. Marshall had to consider a number of factors regarding taking his wife home. He had to decide the possibility of continuing to live in South Africa with his wife whilst she was in a terminally ill state, where no one else but himself could take care of her. This was a decision in which Marshall had to also consider the feelings of his wife's family who would be angry with him in the event that their daughter died in his care, hundreds of miles away. He had to make cultural considerations as well. So he made arrangements with his family to take back his wife to her maternal home in Zimbabwe. For Marshall this was the longest journey ever to Zimbabwe, taking his terminally ill wife home, especially considering that he was losing her. Mucha passed away on the Zimbabwean side before they could get to her home.

(IDI 1 Male Zimbabwean, December 2008)

*Not their real names

The experience described above is not an isolated incident as the notion of returning home for healthcare or for burial is a phenomenon that is common amongst many African (see also Singh 2005) migrants. Anecdotes exist too on similar accounts of relatives and friends residing in South Africa who have had to combine their financial resources in order to take home the body of a deceased relative. However, another respondent explained that as an extended family residing in South Africa they agreed to bury a long gone relative (*muchoni*[6]*)* who had strayed away and broken communication. He says no one was prepared to use their finances to foot the repatriation bill of such a relative and so custom had to be broken in that case (IDI 3 Male Zimbabwean January 2009). Only one relative (mother to the deceased) came from Zimbabwe to attend the funeral and in the words of the respondent "it was such a shame burying our auntie like we were burying an animal…just the five of us were present because the rest couldn't come from Zimbabwe" (IDI3 Male Zimbabwean January 2009). As a result of migration customary practices of funerals among Africans are slowly beginning to erode.

Nevertheless the custom of returning home has always been a characteristic of African internal migrants who return from the city when they become unable to work and have to be taken care of by relatives or family or the deceased are buried in their rural village and not in the city cemeteries. This custom continues to prevail in an international migratory setting and as shown in the account Marshall had to make an informed decision of returning home to his in-laws because it would have had serious implications in the event that his wife had died in South Africa. In the RENEWAL survey respondents were asked where they would like to be buried and an overwhelming number (114 out of 118) of Zimbabwean respondents indicated that they would like to be buried in their home country. When the same analysis was run on the location of burial preferences of South African internal migrants, the areas most preferred were Eastern Cape and KwaZulu-Natal as places of burial compared to Gauteng. The chapter that follows will make an attempt to discuss the meanings of these findings.

[6] A *muchoni* can be defined as a person who has gone away for a very long time and does not maintain any links with home either through letter-writing or sending messages or gifts home, basically anyone who cuts ties while in the city or across the border. In the sense of *machonis* who go to Johannesburg they are called *MaJoni*.

CHAPTER 5: DISCUSSION

5.1 Introduction

The study hypothesised that Zimbabwean migrants—particularly undocumented—are most likely to avoid utilizing public hospitals when seeking treatment and use alternative sources of health care. So the assumption is that for the most part when confronted with legal barriers, hospitals are only likely to be one of the available options since migrants could draw on private healthcare (depending on affordability), traditional health care, and also their links with home. However, to a greater extent the hypothesis was challenged by the findings if not nullified, in a number of ways. Only with a few qualifications does the data support the hypothesis in that respondents maintain a transnational health-seeking trajectory in which they either go home to recuperate or to die. But in most cases as will be shown the data available did not fully support the hypothesis. The discussion that follows reflects the findings in relation to the objectives of the study.

5.2 Socio-demographic characteristics of respondents

Regarding the study population, the findings indicate an interesting trend or pattern of accommodation among Zimbabwean migrants in the innercity of Johannesburg. The suburbs involved in the research were found in the RENEWAL study to have a greater number of Ndebele speaking people than the Shona speaking. Within the home country, Zimbabwe the Shona are numerically larger than the Ndebele and the recent growth in numbers of Zimbabweans in South Africa indicate that perhaps the Shona speaking people have begun to migrate in greater numbers into South Africa. Only two respondents originated from Harare and the same is true for other areas outside Matabeleland where Ndebele is spoken.

Apart from ethnicity, an important aspect to note about the study population is the gender dimension in which the respondents are unevenly split (55% male and 45% females). However, the analyses showed very little gender differences in illnesses experienced (males=13 and females=12). Only two women recorded health-seeking

behaviour for medical conditions of peculiarity to women such as cervical/vaginal infections. In most cases women tended to report more health-seeking strategies than males since the health of the family is traditionally the responsibility of women. Perhaps in this study since very few households have children this could explain the lower rates of help-seeking.

5.2 Factors influencing the utilization of health care services

Health status:

The excellent health status of the Zimbabwean migrants interviewed in the RENEWAL survey possesses interesting linkages with theories of "selective migration" or the healthy migrant hypothesis. These theories argue that immigrants tend to be a healthy and resilient group of people, willing and able to respond to the myriad possible health hazards of migration. Because they are more willing or able to risk change, migrants respond more successfully to the challenges of adaptation (Im and Yang 2006). According to Newbold (2005) recent migrants are more likely to rank their health high and they are most likely to have chronic conditions or disability, attributed to the fact that those in good health are more likely to immigrate. This is especially relevant to the bulk of the 118 Zimbabwean respondents who are mostly prime-aged and they come to South Africa in search of better opportunities they have also been in South Africa only for a while i.e. less than three years.

However, despite the popularity of the healthy migrant hypothesis among numerous studies as a plausible explanation for the healthier state of newly arrived migrants, Rubalcava et al (2008) argue that none of these provide scientific evidence to support the hypothesis. They argue so because, among other factors, scholars tend examine the health status of migrants after they have relocated to another country rather than prior to migrating (Rubalcava et al 2008: 78). Likewise this study examines the health of Zimbabweans after arrival in South Africa and so the healthy migrant effect may not provide a plausible explanation for the good health status of Zimbabweans.

Reported illnesses:

This is the most pertinent issue to the study because it is central to the research question as well as the hypothesis. The finding that the majority, 76 (64%) reported never having been sick, reversed the perceived assumption of the study that issues of health are of high importance to Zimbabwean migrants in general. The assumption was that Zimbabwean migrants were more likely to seek healthcare because they were coming from an area of poor healthcare facilities, and that the migratory phase could negatively impact their health as well as their post-migratory living conditions in Johannesburg. A possible explanation for the smaller number of respondents who reported ever falling sick could be that, issues of health are likely to be the least mentioned problems among Zimbabwean migrants. This finding concurs with the findings on Zimbabwean migrants which indicate that healthcare is ranked the lowest in order of priority of their needs (Landau 2008, Makina 2008). In Makina (2008)'s study the only healthcare related problem that was identified as a pressing need by Zimbabwean respondents was HIV counselling. It was rated sixth after refugee status, business, work permit, employment, and UN assistance. Another study by Landau (2008) found that when NGOs working with immigrants were asked to name Zimbabweans' key needs, the two they mentioned most were 'documentation' and 'accommodation', closely followed by 'employment'. 'Food' was fourth, with 'access to health care', 'protection from police harassment', and 'public xenophobia' tied in fifth place, followed by 'access to schooling' (Landau 2008:10).

However, the anticipated priority given to the issue of health as a priority is that perhaps what needs to be considered is the way in which health is understood by the respondents. When one takes into consideration, the definition of health that is provided by the World Health Organisation, quoted at the beginning of the research report, the absence of disease does not mean migrants are healthy. Their health comprises achieving their different needs, which in turn gives them peace of mind and the opportunity to choose how they take deal with actual disease, should this arise.

The present study also found differences between Zimbabwean migrants' health needs differed from those of other migrants, the Somali migrants. Somali migrants who were studied by Pursell (2005) had health needs that are typical of their culture. For example, due to the general practice of female circumcision the majority of the

women were most likely to undergo caesarean section when giving birth and not have a natural birth. The Somali women in the study used the gynaecology and obstetrics department more than any other department. (Pursell 2005: 35). This does not mean that other international migrants or South Africans do not undergo caesarean section.

In sum, the findings of the study as well as studies such as Makina (2008) and Landau (2008) show that Zimbabwean migrants have a range of immediate and pressing needs. Access to healthcare is only a priority for the small percentage who seem on the whole to be healthy.

5.3 Experiences with accessing healthcare

Out of 17 respondents who needed to access healthcare, 11 consulted a government healthcare facility. What is fascinating is that the relationship between migrancy and healthcare utilisation is not as easy to establish as anticipated in the study design. Legality status was not cited by the respondents as a hindering factor for accessing healthcare in government hospitals. Instead the respondents identified the same determinant factors as those that are likely to affect sedentary or non-migrant populations, for instance, proximity of hospital as a determinant for choosing a certain healthcare provider. Explanatory models such as the Wellar et al and the Kroeger models (cited by Hausmann-Muela et al 2003) show that health resources, such as transport costs, roads, medical insurance etc are important determinant factors for one's utilisation of healthcare facilities.

The respondents expressed satisfaction with the treatment offered at the public hospitals. The acknowledgement of satisfaction with quality of service concurs with the framework of the Kroeger model (cited by Hausmann-Muela et al 2003: 13) which propounds that among the important factors for health-seeking behaviour are the characteristics of the health facility. These can also be called health service system factors and enabling factors comprising: accessibility, appeal, quality, acceptability, communication, costs. However, not all the respondents held the same feelings of

satisfaction as the qualitative study found that a female patient said that she felt the nurse who dressed her wound was tightening the bandage as a way to "fix" her (IDI4 Zimbabwean Woman 2008).

In a sense, migrancy as a factor influencing access to health for migrants is not always a thorny issue. A possible reason why the respondents in the survey were able to access services easily is that Ndebele-speakers do not face language barriers because they can speak Zulu, unlike the Shona, Francophone or Somali migrants, for example. Their ability to speak Zulu means that they may not be detected as foreigners and so will get better treatment than their counterpart foreigners with language problems. In Pursell (2005)'s study language is a serious barrier for Somali migrants especially the women who have to engage an interpreter when seeking treatment at the hospital. In most cases their interpreters tend to be male Somali and this deters them from stating freely their problem to the doctor. So, Zimbabwean migrants who can speak fluently vernacular South African languages such as Zulu and Sotho are not likely to face discrimination at the state health facilities.

5.4 Alternative sources of healthcare

The research had envisaged that the respondents would resort to traditional healers or spiritual healers for alternative healthcare but the results of the survey did not point to any particular incidences in which they made mention of that. The qualitative study did not probe the issue also. The alternatives to healthcare that are mentioned in the RENEWAL survey relate to alternative strategies of help-seeking in the event of chronic illness. The likelihood was that migrants would return to their homes to recover or sadly, in Sigh (2005)'s expression "return to die" at home. This is an important dimension to health because as the political economy of health model (Nunez 2008) illustrates, countries such as South Africa which require labour, tend to recruit the healthy and only "spit them out" when they become unfit to continue rendering their services. Health would appear to be an important determinant for one to remain employed and even though there are better health facilities in South Africa, the sick migrant may prefer to go home where medicines are scarce but, care is available (see also Roux and Van Tonder 2006). Another interesting aspect which

emerged from the case study (Box 1) is that there is evidence to suggest that health-seeking behaviour is transnational for some migrants hence the decision to return home to be well-looked after. Added to this decision making for treatment or taking care of a sick person is transnational. In the case study Box 1 Marshall, the respondent considered the wishes of his in-laws when he reached the decision to take his ailing wife to her maternal home in Zimbabwe. Even though his wife died along the way, this was better than if she had died in South Africa, because her relatives would have felt that Marshall had excluded them from taking care of their daughter—something which was culturally unacceptable. All in all this points to the existence of a strong link between migration and health.

5.5 Conclusion

On the whole the survey provided useful insights into an area that is not yet widely known—the current healthcare utilisation patterns of Zimbabwean migrants in South Africa. The qualitative interviews served the purpose of 'marinating' these findings by illustrating specific cases where migrants faced a certain healthcare problem. It should be acknowledged that the study findings however, have a bias in the profile of migrants interviewed who appeared to mostly be Ndebele, although this was not a deliberate, conscious effort on the part of the researchers. Random sampling still led to a sample that was largely represented by respondents originating from Matabeleland.

CHAPTER 6: CONCLUSION

The report has made an attempt to explore the dynamics of health care utilisation patterns of Zimbabwean migrants residing in Johannesburg, South Africa. It has shown that there are a number of factors which determine the utilisation of public health facilities by Zimbabwean migrants. Some of the factors are length of stay in South Africa, self-reported health status, closeness of health facility, the nature of the health problem and whether its severity warrants seeking help. Length of stay was an important variable in explaining the health-seeking behaviour of the respondents. It can be argued that due to their relatively short length of stay in South Africa (>3years), Zimbabwean migrants are likely to report their health status as good because of the healthy migrant effect. The need to seek medical attention arises after people have spent a considerable length of time in the Republic. Certain factors such as gender have not shown any great significance in the way the respondents in the survey sought help for treatment.

The findings supported and disproved some of the presumptions of the researcher with regards to the socio-economic and legal factors that influence the utilisation of health care facilities by the Zimbabwean migrants. The findings support the Anderson healthcare utilisation model which shows that use of healthcare facilities is based on enabling factors e.g. eight out of fifteen respondents chose to utilise a healthcare service because it was nearest to their place of residence. This is an important aspect because health-seeking behavioural models do not usually take into consideration factors that are of typical of mobile populations. For example, migrant status could play a more significant role than proximity of healthcare facility or severity of illness. But as the study has shown, Zimbabwean migrants took into account the affordability and proximity of health care facilities instead of their legal/immigration status. As already noted in the previous chapter, the language proficiency of the respondents in the RENEWAL survey could explain why none of them were discriminated against by health personnel at the government health facilities.

However, the findings do not support the hypothesis that Zimbabwean migrants—particularly undocumented—are most likely to avoid utilising public hospitals when

seeking treatment and use alternative sources of health care. Instead the findings have shown that legal status is not mentioned by any of the respondents as a deterrent to accessing healthcare except for the qualitative study in which one respondent stated that her 'undocumentedness' did not deny her treatment as such but it limited her choices of health care services. Migrants seem to know the appropriate healthcare centres to go to when they need to access treatment.

The experiences of migrants who tried to access health care show that on the whole, Zimbabwean migrants who participated in the survey were not denied treatment and the majority were satisfied with the treatment they received. Almost all respondents 16 out of 17 indicated that they received the treatment that they wanted and they were satisfied by the quality of the treatment. This is not what the researcher had envisaged prior to the study. The researcher had anticipated that respondents would indicate similar experiences as those reported in advocacy work on access to health care for migrants which report that migrants are denied treatment in public health facilities in South Africa. Instead respondents from the RENEWAL survey indicated that they had received treatment at public health facilities. In the qualitative study and in the researcher's informal conversations with Zimbabwean migrants indications were that, there are serious delays and long queues at government hospitals and that hospital staff were often hostile but they did treat patients even after 'insulting' them.

In terms of alternative sources of health care, the migrants indicated that they would go home if they were chronically ill. Going home was motivated by the fact that there would be relatives to take care of them in Zimbabwe unlike in Johannesburg. Their South African counterparts also shared the same sentiments of preferring to return home to KwaZulu-Natal or Eastern Cape so as to recuperate or die. A descriptive account of Marshall, a Zimbabwean respondent who had to take his wife back home so that she could be taken care of by her relatives, illustrates the transnational dimension of health-seeking behaviour amongst Zimbabwean migrants.

The study has its weaknesses. Due to time constraints, the researcher was unable to conduct follow-up qualitative in-depth interviews with the respondents who had participated in the RENEWAL study.

Another limitation relates to the small size of the sample. A larger sample could have addressed some of the pertinent aspects of the study. It is difficult to generalise the experiences of 17 out of 118 Zimbabwean respondents (who tried to access health care treatment at government hospitals) to the rest of the Zimbabwean population residing in South Africa.

The purpose of the study as an academic endeavour limits the issue of representativity and the objective of making recommendations for addressing policy concerns. Further studies could broaden their objectives and cover a larger sample of Zimbabwean migrants in South Africa. Considering the diversity of Zimbabwean migrants in terms of categories mentioned in Table 1 in Chapter 1, as well as ethnic composition of Zimbabweans, educational levels and their length of stay, it would be noteworthy to compare how these factors affect issues of access to health care.

On the part of the present researcher, this has been a fruitful exercise. The study has equipped me with useful quantitative techniques such as analysing data through JMP 5.1 statistical software. Also the researcher has learnt the integration of quantitative and qualitative research techniques in a research report. On the whole the findings of this research report could be contested as a result of some oversights by the researcher, but it is hoped that the report opens an opportunity to debate issues of access to healthcare, with special reference to Zimbabwean migrants who reside in South Africa.

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Appendix 1: Contract Migration to the South African Gold Mines, 1920-95

Year	Ang	Bots	Les	Mal	Moz	Swa	Tan	Zam	Zim	Other	Total
1920	0	2 112	10 439	354	77 921	3 449	0	12	179	5484	99 950
1925	0	2 547	14 256	136	73 210	3 999	0	4	68	14	94 234
1930	0	3 151	22 306	0	77 828	4 345	183	0	44	5	99 355
1935	0	7 505	34 788	49	62 576	6 865	109	570	27	9	112 498
1940	698	14 427	52 044	8 037	74 693	7 152	0	2 725	8 112	70	168 058
1945	8 711	10 102	36 414	4973	78 588	5 688	1 461	27	8 301	4 732	158 967
1950	9 767	12 390	34 467	7 831	86 246	6 619	5495	3 102	2 073	4 826	172 816
1955	8 801	14 195	36 332	12 407	99 449	6 682	8 758	3 849	162	2 299	192 934
1960	12 364	21 404	48 842	21 934	101733	6 623	14 025	5 292	747	844	233 808
1965	11 169	23 630	54 819	38 580	89 191	5 580	404	5898	653	2 686	232 610
1970	4 125	20 461	63 988	78 492	93 203	6 269	0	0	3	972	265 143
1975	3 431	20 291	78 114	27 904	97 216	8 391	0	0	2 485	12	220 293
1980	5	17 763	96 309	13 569	39 539	8 090	0	0	5 770	1 404	182 449
1985	1	18 079	97 639	16 849	50 126	12 365	0	0	0	4	196 068
1990	0	15 720	108780	72	50 104	17 816	0	0	2	0	192 044
1995	0	12 736	100892	2	73 874	16 753	0	0	0	0	204 257

Note: Ang = Angola, Bots= Botswana, Les= Lesotho, Mal= Malawi, Moz=Mozambique, Swa=Swaziland, Tan= Tanzania, Zam=Zambia, Zim=Zimbabwe

Source: Crush (2000), Statistics adapted from The Employment Bureau of Africa (TEBA)

Appendix 2: Question guide for Qualitative Study

Opening questions

1) Tell me about yourself, when you came, what you do etc?
2) What was your life like in Zimbabwe?
3) What brought you to South Africa and how do you see life here?

Key questions on health

4) What health problems do you have?
5) How do you sort them out?
6) Can you think of the impact of mobility on health?

Key questions on service utilisation and discrimination

7) What is your experience of the local services such as GPs, public hospitals etc?
8) Have you ever been discriminated? What happened then? How does that affect your health?
9) Of all the health needs which we discussed, which one do think is the most important to the Zimbabwean community in general?

Final questions

10) Is there anything else that we should have talked about that we did not?