

https://dspace.org/

# Africa Centre for Migration and Society (ACMS)

**Mvundura, Learmore**

**2018**
https://hdl.handle.net/10539/29379

Downloaded from a DSpace repository. https://dspace.org/




**Masters by Dissertation Research Report**

**Africa Centre for Migration and Society (ACMS)**

**Name:** **Learnmore**

**Surname:** **Mvundura**

**Student No:** **1537028**

**Supervisor:** **Jo Vearey, PhD**

**Topic:**

# "I put my religion first": Interests, ideas, and institutions that influence the provision of healthcare services to migrants in Vhembe, Limpopo, Republic of South Africa

A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Arts in Migration and displacement

Johannesburg 2018

# Declaration

I declare that this dissertation is my own unaided work. It is submitted to the faculty of Humanities, University of the Witwatersrand, Johannesburg, for the degree of Masters of Arts (Dissertation). I declare that it has not been submitted for any degree or for examination in any other academic institution

Learnmore Mvundura

# Abstract

For many, migration is a livelihood strategy and contributes socially and economically to the receiving and sending communities and for these benefits to be realised migration has to be managed in a healthy way. Despite this fact, there are negative perceptions about migration globally and in South Africa, particularly cross border migration. Many continue to see migrants as a threat that needs to be contained. Migrants are seen as overwhelmingly many; as a burden on national resources including healthcare facilities; as criminals; and as migrating solely for health seeking purposes. These are unjustified claims without empirical basis. Negative perceptions concerning migrants lead to challenges in accessing primary health care facilities. Sub-Saharan Africa constitutes about 70% of HIV/AIDS cases globally and a greater proportion of these are in South Africa. Non-communicable diseases have also been on the rise in the region and in South Africa. Migration, both internal and cross border, is a significant phenomenon in South Africa pre and post-Apartheid and human mobility, in a context of high disease incidence, has to be considered in policy. Programmatic interventions in the country do not sufficiently engage with population mobility and many migrants face challenges in accessing healthcare services. Service provision and practices at the local level do not always correspond with the little policy that exists. Limpopo, a province in South Africa that borders neighbouring Zimbabwe, is home to a significant number of cross border migrants. This study aimed at investigating whether interventions which involve grassroots NGOs and state primary healthcare facilities in Makhado Municipality, Limpopo, consider human mobility and whether the individual behaviours of workers of organisations and government facilities involved in primary healthcare service provision and gender based violence services influences whether and how these services are provided to migrants. The study also sought to investigate the source of the observed behaviour. The study harnessed Street level Bureaucracy (Lipsky 1980; 2010) and The Institutional Theory (Scott; 2014) as theoretical tools. Semi-structured interviews were conducted with public healthcare providers and workers of NGOs. Findings reveal that interventions do not explicitly consider human mobility and provision of services to migrants is uncoordinated and relies upon the discretion and empathy of the service providers. NGOs provide services on the basis of their own observation and discretion, and not in response to explicit programming on population mobility. State public healthcare facilities also do not have programmes that consider migration. Whilst the nurses' holding of negative perceptions about migrants was consistent with that observed in literature, they reported not denying services to migrants owing to their

cultural and religious persuasions. The study concludes that the provision of services to cross border migrants should not be based on the conscience and mercy of the services providers; it should rather be based on organised coordinated responses and frameworks that consciously and deliberately engage with population mobility.

# Dedication

I dedicate this work to the African child who is bogged by various circumstances to pursue what I have achieved.

# Acknowledgements

To the Almighty God who has made me like unto him in this world. This dissertation would not have been possible without the excellent supervisory skills of Dr Joanna Vearey and I am grateful for her dedication despite her tight schedule and multiple commitments. I would also like to express gratitude to the Margaret Pyke Trust that availed funds for the pursuit of this academic project. I acknowledge the assistance by Ellen of TVEP who assisted me in the field in locating various stakeholders and localities I was not familiar with. Last, I am thankful and appreciative of the encouragement I got from my parent, David and Vailet Mvundura, who, when I said it was tough, encouraged me that it would be all over in due time.

# Contents

Declaration.... 3

Abstract.... 4

Dedication.... 7

Acknowledgements.... 8

List of Acronyms/ Abbreviations.... 13

Chapter 1.... 14

1.1 Introduction and background to the study.... 14

1.2 Structure of the report.... 18

2 Chapter 2.... 19

2.1 Literature Review.... 19

2.1.1 Disease burden in SADC.... 19

2.1.2 Migration and Health.... 19

2.1.3 HIV/AIDS and Migration in South Africa.... 21

2.1.4 Migrants' access to health.... 24

2.1.5 Tracking programmatic interventions on HIV/AIDS and STIs in South Africa 26

2.1.6 Decentralisation and local government in South Africa.... 28

2.1.7 The South African governance structure: the health system.... 29

2.1.8 Non-Governmental Organisations – State partnerships in healthcare provision 31

2.2 The Study's intellectual site: Framing the study.... 33

2.3 Research Question.... 34

2.4 The study's physical site.... 34

2.4.1 The Makhado local Municipality.... 35

Chapter 3.... 36

3 Theoretical Underpinnings.... 36

3.1 Institutional Theory.... 36

3.1.1 The Regulatory Pillar.... 37

3.1.2 The Normative Pillar....39
3.1.3 The Cultural-Cognitive pillar....40
3.2 Street level bureaucracy.... 41
3.2.1 The theory's key thesis....42
3.2.1.1 Lack of resources....43
3.2.1.2 Lack of clear goals.... 43
3.2.1.3 Providing services to clients who have no immediate alternative sources..... 43
Chapter 4....43
4 Methodology....43
4.1 Introduction.... 45
4.2 The Study Site.... 45
4.3 Research Participants....45
4.3.1 Health Care Providers / Street level bureaucrats....47
4.3.2 Grassroots Management....47
4.4 Selection of Participants....47
4.5 Research Instruments....48
4.5.1 Interviews....48
4.5.2 Conversations....48
4.5.3 Field Notes.... 49
4.6 Data Analysis....49
4.6.1 Interim Analysis....49
4.6.2 Thematic and Comparative Analysis.... 50
4.7 Practical and Ethical Considerations....50
4.8 Limitations of the study....51
5 Chapter 5....53
5.1 Factors influencing grassroots organisations to provide services to target population 53

5.1.1 Introduction.....53

5.1.2 Context and location of the grassroots organisations - Makhado and Kutama-Sithumule.....54

5.1.3 The scope of services provided by the grassroots organisations and its structure 55

5.2 'We know what we talk about': Interventions kindled by empathy, volition and emotions..... 58

5.3 Organisational goals as institutions: Ability of NGOs to navigate the politics of funding.....73

5.4 'We challenge them according to their own stipulations': The working relationship of the government and community organisations..... 84

6 Chapter 6.....95

6.1 Factors influencing the provision of public healthcare services by public healthcare professionals to migrants.....95

6.1.1 Introduction.....95

6.2 Factors external to the bureaucratic sphere influence the conduct of street level bureaucrats.....96

6.2.1 Street level bureaucrats' discretion and district expectations..... 96

6.2.2 The transposition of schemas from elsewhere into the work setting..... 101

6.3 Loving and hating at the same time: An antithesis in the provision of health care to migrants..... 111

7 Conclusion..... 119

* .....* *

.....120

References.....121

APPENDICES.....129

Appendix 1: Information Sheet for TVEP Management.....129

Appendix 2: INFORMED CONSENT: TVEP Management.....131

Appendix 3: Consent form for audio-taping of the interview: TVEP Management..... 133

Appendix 4: Information Sheet for Nurse providing services to migrants..... 134

Appendix 5: INFORMED CONSENT: Nurses.....136

Appendix 6: Consent form for audio-taping of the interview: Nurses.....138

Appendix 7: Wits University Ethics Clearance Certificate: Non-medical.....139

Appendix 8: Limpopo Provincial Department of Health Approval Letter.....140

Appendix 9: Vhembe District Approval Letter.....141

Appendix 4: Interview Guide – Grassroots Organisations' Management Staff.....142

Appendix 4: Interview Guide: Public Healthcare Professionals.....144

# List of Acronyms/ Abbreviations

| | |
|---|---|
| TVEP | Thohoyandou Victim Empowerment Project |
| TsVEP | Tshilwavhusiku Victim Empowerment Project |
| VPBP | Vhumbanani Peace Building Project |
| ZTA | Zero Tolerance Alliance |
| ZTVA | Zero Teolerance Victim Alliance |
| ZTSA | Zero Tolerance School Alliance |
| NGO | Non-Governmental Organisation |
| OP | Operational Manager |
| M & E | Monitoring and Evaluation |

# Chapter 1

## 1.1 Introduction and background to the study

Human movement is a global phenomenon and 3% (about 214 million) of the global population are cross-border migrants and these global patterns in migration match trends in South Africa (El-Khatib et al, 2013; Africa Check, 2016). South Africa is no stranger to both internal and cross-border migration owing to the migrant labour regime in the apartheid era and better economic opportunities in the Southern African Development Community (SADC) post-apartheid (Kark 1949; Matjila et al 2008; Lurie et al 2000; Lurie & Williams, 2014). Migration is a livelihood strategy globally, regionally and nationally and many migration movements in South Africa revolve around this fact (IOM, 2008; Africa Check 2016; Vearey 2008, 2011; Vearey, Nunez & Palmary 2009, Landau & Wa-Kabwe Segat`ti 2009; UNDP 2009). Migration and the circumstances under which it occurs is a determinant of health (MacPherson & Gushalak, 2001; Vearey 2008, 2011). Migrants are usually healthy at point of departure but circumstances under which they travel and challenges faced in host communities leads to deterioration of health and the need for primary healthcare services (PHC) arises (Lu, 2008; Lu & Qin, 2014; Chen, 2011; Crush, 2002).

Notwithstanding this evidence migrants are seen as migrating for health-seeking purposes, as careers of disease; and this, among reasons including anti-foreigner sentiments on the part of host communities, language barriers and documentation; migrants face various challenges in accessing healthcare services in host countries (Grove & Zwi; 2006; Vearey 2008, 2011; IOM, 2008; Africa Check, 2016; Vearey, 2014). Such challenges in accessing primary healthcare services are worrisome considering that SADC, and particularly South Africa has a high burden of communicable disease and Non-Communicable Disease (NCDs) which have proven to be increasing too (Vearey 2014; IOM 2008). Sub Saharan Africa contributes to the 69% of around 34 million people that are HIV positive globally (UNAIDS, 2012; Suphanchaimat et al, 2014; Weine & Kashuba, 2012). Studies have been conducted that draw linkages, however complex and contested, between migration and communicable diseases especially Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs) (Kark 1949; Matjila et al 2008; Lurie et al 2000, Hunter 2010; Vearey 2016; Lurie et al 2000).

Whilst this literature draws links between migration and diseases, it is observed that the findings must not be misconstrued to mean that migration equals disease. It is in light of these observations calls have been made for the need of the consideration of migration in programmatic interventions (Vearey, 2011b; Vearey 2010 on World Health Assembly 2008, SADC 2008; and Deanne et al, 2010).

The South African health system is not structured in a way that considers population mobility. The study conducted by the International Organisation for Migration states that the South African health system is structured and designed for sedentary populations. The study further states that migrants, internal and cross-border alike, need a health system that takes into consideration the fact that migrants are very mobile and can live anywhere, including unhealthy locations, as long as there are employment opportunities that enhance their livelihoods (IOM; 2008). Crush (2002) speaks of 'spaces of vulnerability' which are 'spaces that contain a combination of social, economic and physical conditions that increase the likelihood of exposure to, and acquisition' of diseases (Vearey, 2014.p 2). Many migrants are exposed to these and responses in both South Africa and SADC do not sufficiently recognise these factors, and when they do the scope in implementation is limited (Walls et al, 2016). Responses that address migration in the region have taken migration to mainly mean cross-border movement and any discussions on migration consequently gravitate towards securitisation and strengthening of national borders (Vearey 2014; Moyo, 2010). It is therefore not surprising that policy documents, many of which are stated below, that make reference to migration do not explicitly engage with the phenomenon of internal movement within South Africa.

Appeals for the national health system to consider migration are very important. Since South Africa as a country and SADC as a region still lag behind in programmes that are aware of population mobility, it is justified that scholars make pleas on the central government to structure the health system and come up with programmatic interventions that are cognisant to migration. South Africa has some policies that guarantee access to health services by everyone. The South Africa Constitution (Constitution of South Africa, 1996) guarantees access to services by all in South Africa. The National Health Act of 2004 and 2013 (Government Gazzete, 2004 & 2013), The Department of Health Memo (Department of Healht, 2007), and the Gauteng Department of Health Memo of 2008 (Gauteng Department of Health, 2008) echo the Republic's guarantees and further state that no treatment should be denied on account of nationality or documentation. The Refugee Act: No. 130 of 1998

(Department of Home Affairs, 1998) also makes the provision that refugees are entitled to the same services as the citizens of the Republic of South Africa. However, as stated above, these provisions do not always inform practice. More so, key policy documents on sexual and reproductive health (SRH) like the South African National Strategic Plan (NSP) on HIV/AIDS, TB and STIs (South African AIDS Council, 2007, 2012, and 2017), while explicit on the right of non-citizens to access healthcare services, do not state how these guarantees will be put to practice especially considering that the health sector is not structured in ways that consider migrant populations. Others also maintain that the provisions in policies cited above are vague especially on undocumented migrants (Vearey & Richter, 2008) and that the Republic seems less obligated to this category of migrants and for these migrants to claim entitlement based on these provisions is putting a stake on ambiguity and uncertain provisions (Moyo, 2010). It is therefore critical and justifiable that due focus be given on what the central government does with respect to the health of migrants in the country.

Yet, a focus on processes in the national government should in no way obfuscate processes at the facility level where practical interactions between client and service provider occur as this is important in understanding how practices there relate with national policy. Using Lipsky (1980), Moyo (2010) has demonstrated that practices at the local level are not always in agreement to written policy for they rely mainly on the discretion of the workers and these practices may be good or bad for the users of the services offered. Others (Maynard –Moody & Musheno, 2000, Walker & Gilson, 2004) have done the same studies (though these studies were not on migration), and came to the same conclusions. This is explained in part by the fact that the South African health system, while it is decentralised, there is still disgruntlement on the part of those in local governments concerning being left out in the policy development matrix (Siddle & Koeble, 2013; McIntyre, Thomas, Mbatsha, et al 1999; McIntyre and Klugman, 2003). With such schisms between the policy development and implementation spheres, one is left wondering how the local level which is the presumed implementation sphere relate with migrant populations in a context of disgruntlement with the national government, high disease incidence and population mobility.

In South Africa the state is not the only player in providing services especially at the local level. The IOM (2008) highlights the role of local level NGOs including religious organisations in providing services to migrants in the Mussina region in Limpopo. While sometimes working alone, these NGOs can also collaborate with the state to provide services

at the local level (Bratton, 1989; Gilson et al 1994; Keagan & Tollman, 2008; McIntyre & Klugman, 2003; Loevinson and Harding, 2005; Batley, 2010; Natalie, Schneider & Daviaud, 2012; Schneider, Hlope & van Rensburg, 2008; Acharya et al 2017). This scholarship states the importance of public-private partnerships for efficient provision of services in the primary health sector in deprived contexts.

Limpopo province, South Africa, is a province that has a significant share of both internal and cross-border migrants. While statistics are not easy to come by on exact figures, the IOM and Africa Check states that Limpopo is home to a significant number of especially Zimbabwean foreign nationals (IOM, 2008; Africa Check, 2006). A significant number of migrants in Mussina (a border town in South Africa neighbouring Zimbabwe), Limpopo, consist of "young, economically active age group with strong economic motives, and largely single and unattached' (IOM, 2008.p3). The report states that these are characteristics of very mobile people prepared to live anywhere as long as opportunities for employment exist. It is further stated that border areas are one of the intended destination areas for migrants in Limpopo. Africa Check also state that foreign nationals from Zimbabwe prefer to stay in Limpopo due to somewhat similar cultural backgrounds, commonalities in language spoken and closeness to area of origin (Africa Check, 2006). The same report goes on to say that Zimbabweans who settle in most parts of Limpopo are usually employed in low skilled work as farm labourers.

The Margaret Pyke Trust and the European Union provided funding to three grassroots NGOs (Thohoyandou Victim Empowerment Project (TVEP); Tshilwavhusiku Victim Empowerment Project (TsVEP); and Vhumbanani Peace Building Project (VPBP)) in Vhembe District, Limpopo South Africa to provide SRH services to various populations (These organisations have no specific programming that target migrants; migrants are just part and parcel of the larger community). The project was done in collaboration with state facilities i.e. clinics, magistrates' courts, the prosecution authority and police services. This study was part of a broader evaluation of this project and funding was provided by The Margaret Pyke Trust. The purpose of the study was to investigate how, in a context of high population mobility and a high burden of disease; a disgruntled local government sphere; and a health system not designed to cater for migrants, does service provision and interventions at the local level relate with migrant populations. The study also aimed at investigating whether and how the behaviour of the employees of organisations and facilities involved can be useful in explaining this relationship.

## 1.2 Structure of the report

The following sections of the report are structured as follows; chapter 2 gives a comprehensive literature review exploring themes identified in literature; the study's physical site and the main research question and the sub questions. Chapters 3 and 4 centre on the theoretical tools and the methods used in the study respectively. Chapter 5 and 6 presents the findings and chapter 7 gives conclusions based on the findings.

.

# 2 Chapter 2

## 2.1 Literature Review

This chapter explores the key themes identified in the literature reviewed in this study.

### 2.1.1 Disease burden in SADC

Approximately 34 million people live with HIV and/or AIDS globally and the Sub-Saharan part of Africa constitutes more than two thirds of that statistic (UNAIDS, 2012; Suphanchaimat et al, 2014; Weine and Kashuba, 2012). These figures have not changed significantly to date. The Southern African Development Community (SADC) is burdened with communicable diseases (HIV, TB and Malaria) and these are argued to be the greatest cause of mortality and morbidity in the region, and migration has been recognised as a factor in their spread (SADC 2009; Vearey 2014; Matjila et al 2008). The control of communicable diseases has thus been considered a priority in the region (SADC 2009). South Africa, a member state of SADC, has a burden of disease which reflects patterns in the region. The history of HIV/AIDS epidemic is connected to the role of migrant labour in South Africa and calls are made that in the present context, while population mobility might still be a factor in HIV/AIDS epidemiology, there is need to consider the complexities and contestations that characterise the narrative that migration equals HIV/AID (Shisana, Rehle, Parker, Zuma, Bhana, Connolly *et al*., 2005; Devey, Skinner & Valodia, 2006; Hunter, 2007; Vearey *et al*., 2010; Richter et al, 2014). Thus South Africa is confronted with an epidemic that is connected, though in complex and contested ways, to population mobility. It is observed that human movement is a determinant of health which requires consideration in programmatic interventions (Gushalak and MacPherson 2009). These discussions prove the importance of the need to consider population mobility in discussions and programmes that are HIV related.

### 2.1.2 Migration and Health

Migration is a livelihood strategy for households, and where migrants provide resources to their households (mostly material), migration makes social and economic development contribution to all the people along the migration trajectory (Vearey, Nunez & Palmary 2009; Vearey 2011; Collinson; Vearey; Bocquier et al, 2010). Landau and Wa Kabwe -Segatti (2009) further argue that migration contributes to social and economic development at the national level for the receipt community. It is stated that the migration of skilled and semi-skilled labour into South Africa contributes to the meeting of its long term developmental goals including Millennium Developmental Goals (now Sustainable Development Goals), courtesy of migrants' skills and entrepreneurism driven by their work ethic and work imperative (ibid). It is also observed that migrants have potential to fill a significant skills gap in South Africa caused by flight of South African skilled professionals (Department of Labour 2005; Ellis 2008). These empirical observations show how crucial human movement is since all the points (departure, transit and destination) along the migration trajectory can potentially benefit from migration. However, these observations are contested especially in host communities which see migrants as threat that is in need of containment (Turton, 2003; Landau & Wa-Kabwe Segatti 2009).

In spite of evidence cited above, human mobility in South Africa and the world over is understood in terms of threat, evidenced by metaphors (e.g. swamps, floods; saturate) used in conceptualising mobility–language that portrays mobility as a menace in need of riddance (Turton 2003). Migrants are portrayed as overwhelmingly many, a discourse which feeds into and coincides with another popular narrative which posits that migrants primarily move to seek health services; that they are a burden on national health facilities of host communities; and that they spread disease (Amon and Todrys 2009; Harper and Raman 2008; Southern African HIV Clinicians Society & UNHCR, 2007; Vearey & Nunez 2010). This is in spite of empirical evidence which suggests otherwise. Vearey, Nunez and Palmary remind us that migrants do not move for health seeking (there are few exceptions though– but exceptions should remain as such and not constitute rule or norm) (Vearey, Nunez & Palmary 2009). It is widely observed that migrants migrate for seeking better livelihood opportunities or fleeing persecution in their countries of origin; that those who move are the healthy (the healthy migrant effect – Lu (2008)); that illness sets in once in host communities due to lack of positive determinants of health; and that in cases of severe illness migrants go back to their home countries to receive care (CoRMSA 2009; Vearey, Nunez & Palmary 2009; Collinson et al 2006; Collinson 2010; Clark et al 2007). Notwithstanding this evidence, popular

discourses still hold sway and inform many interventions that address migration issues. These discourses have been argued to lead to the denial of health services among other services; practices that exposes migrants to multiple challenges in their quest for health and wellbeing (Grove & Zwi 2006; Moyo 2010).

It is then acknowledged that denying migrants access to needed health care is a risky practice which has implications for the migrant, the sending and the receiving society. The health of the migrant is inextricably connected to that of the whole population – the wider population is not immune to what ills the migrant (Landau and Wa Kabwe-Segatti 2009) hence the calls to adopt a public health lens when considering migration and health (Vearey 2011). The public health lens sees the health of migrants in light of and in connection to that of the host community. Others note how denying access to healthcare has implications on remittances, and on healthcare systems of host communities and families that will have to shoulder the responsibilities connected with delayed healthcare seeking (Vearey 2011; 2014; Vearey, Nunez & Palmary 2009). It is in line with these observations that calls have been made for programmatic interventions to engage with population mobility from a public health perspective and for migration to be considered a central determinant of health (MacPherson & Gushalak 2001; Vearey 2014; Anarfi 2005). From the preceding discussion, it is beyond doubt that human mobility is an important subject that needs consideration when planning any interventions on health provision.

### 2.1.3 HIV/AIDS and Migration in South Africa

HIV/AIDS and Sexually Transmitted Infections (STIs) prevalence in South Africa is connected, albeit in contested and intricate ways, to historical and present migration patterns. Literature draws linkages between migration and HIV, with others (Kark 1949; Matjila et al 2008; Lurie et al 2003; Lurie 2006) explicitly and in some points implicitly drawing direct causal pathways between the two whilst others (Hunter 2010; Decosas and Adrien 1996; Lurie et al 2000) unravel the complexities and intricacies on these linkages. However, it would be unfair to draw an explicit demarcating line on this literature for some (Lurie 2003; Lurie et al 2006) imply a direct causal pathway between migration and HIV but in certain occasions straddle the boundaries as they problematize this linkage and acknowledge

complexities. Below I explain how there were direct linkages between HIV and migration during the early stages of the epidemic and how this link and pattern is no longer explicitly seen.

The work of Sydney Kark, though it was on the syphilis outbreak and not HIV, played a seminal role on literature that draws direct linkages between human mobility and HIV/AIDS (Kark, 1949). In analysing this work, Hunter coins the term 'male migrant infector model' (Hunter, 2010. p 2) to sum up Kark's observations. This model explains how male migrant labourers under the apartheid migrant labour regime acquired syphilis in the mines and went back home to transmit it to their wives (Hunter 2010). This explanation played a critical role in the understanding of the epidemiology of communicable diseases in the mid-20$^{th}$ century in South Africa (ibid). Considering the issue of context specificity, with context taken to mean time, the explanation was a legitimate one for no diseases pattern had ever demonstrated the effects of population mobility more than the syphilis epidemic in South Africa.

This male migrant infector model got immense reception in the 30s and 40s especially among the native population and anti-establishment scholars who saw this explanation as exonerating the Africans from the stereotypical discourses that explained the syphilis epidemic in terms of African sexual promiscuity (Vaughan, 1991). These politics in the epidemiology of communicable diseases endured even up to the early stages of the HIV/AIDS epidemic in South Africa. Hunter observes that the male migrant infector model won favour among scholars because of '…the urgent need to provide a progressive alternative explanation to racialized narratives of 'African promiscuity' that swirled around discussions of AIDS' (Hunter, 2010: 27). The model however explicitly denoted direct causal pathways between population displacement and disease. Whilst this observation was on point within the context in which it gained ascendancy, I argue that it inadvertently reinforced, and still reinforces the narratives that implicate migrants in the spread of diseases, and this is more so troublesome in the contemporary context where the linkages between migration and diseases, particularly HIV is no longer as straight forward and clear cut as it used to be. I demonstrate this below.

Post 2000 millennium literature has increasingly departed from 'migration equals HIV' conception citing complexities between migration-HIV links. Lurie and colleagues in their study in KwaZulu Natal province of South Africa observe bi-directionality in the spread of

HIV in which the sedentary partner was the one infected in almost one third of the sero-discordant couples (couples in which one partner is HIV positive whilst the other is not) that were studied (Lurie et al 2006). This implied that it is not always the mobile partner who is responsible, and this calls for the need to interrogate other circumstances around human mobility that predisposes people to vulnerability of acquiring HIV (ibid). This does not call for the deletion of migration in HIV discussions, rather is calls for a shift from focusing on the migrant and focus on migration as a process, which allows for the analysis of broader factors around human movement that shape vulnerabilities to HIV and other communicable diseases (Adrien & Decosas 1996). This is echoed by many (e.g. Vearey 2013, 2016; Deane et al 2010) who argue that the lack of standardised measures and definitions of migration in academic pieces stemming from the non-linearity of human movement is a justification of complexities in linkages between migration and HIV. Notwithstanding these on-going discussions, Vearey (2016) and McGrath et al (2015) posit that it is a necessity to work with existing evidence in improving current programmatic responses and this, they further argue, includes working to improve local responses to local HIV and migration contexts.

Thus with evidence pointing to the connection between population mobility and HIV (Hunter 2010; Decosas and Adrien 1996; Lurie et al 2000), and the importance of population mobility managed in a healthy way in contributing to the socio-economic development of all spaces along the migration trajectory (Landau and Wa Kabwe-Segatti 2009), it is justified to say that responses to HIV should engage with migration. It therefore holds that HIV/AIDS is surely connected to population mobility however in intricate and contested ways and that these intricate and complex connections should serve as a platform to justify the need to include population mobility in planning and implementing programmes that are health related. However, literature that has tracked interventions on the health of migrants seems to focus a lot on programmatic interventions at the highest levels of planning i.e. the central government. Vearey speaks of existing global and regional frameworks (the 61$^{st}$ World Health Assembly Resolution 61.17; the Migration Dialogue for Southern Africa (MIDSA, 2009; and various SADC instruments) and how they feed into national imperatives (Vearey, 2011). It is very soothing to see that there is scholarly commitment in tracking policies and programmes that engage with population mobility. Be that as it may, a preoccupation with policy commitments at higher administrative levels implies that higher level commitments will automatically and logically percolate to local level locales. Many have demonstrated that practices at the supposed spheres of implementation do not entirely duplicate and fulfil policy intentions

(Moyo 2010; Maynard –Moody & Musheno, 2000, Walker & Gilson, 2004). I submit that in as much as commitments at the top are crucial (they hopefully frame commitments at the lower-local levels), it is equally crucial to flip the approach and track commitments at the local levels. If Lipsky's 'Street Level Bureaucracy' (Lipsky, 1980) is anything to go by, then lower level (municipal, district and sub-districts) practices and programmes warrant attention for they constitute *de facto* policy making in themselves.

### 2.1.4 Migrants' access to health

The South African constitution's preamble guarantees health access to all within its borders. Here goes the preamble, 'We, the people of South Africa…believe that South Africa ***belongs to all*** who live in it, united in our diversity…'(emphasis mine) (Government Gazette, 1996. p 1) If 'all' is taken to mean everyone with the exception of no one, then everyone, immigrants included, has a constitutional guaranteed access to public services in the republic. Landau (2006b) and Vearey & Richter (2008) note that the constitution is interpreted as guaranteeing health care access to all. This is so because Section 27 of the same constitution states:

1. Everyone has the right to have access to:
    a) Health care services, including reproductive health care
    c) Social security…(and) 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 (Constitution, S.A., 1996. P 11)

However some (Moyo 2010; Vearey and Richter 2008) query these provisions stating that the section is silent on undocumented migrants in that they are not explicitly but impliedly mentioned in 27(3). I concur on the ground that the 'everyone' and 'all' in the Republic constitution are within the parameters of being South African either by means of descent or documentation. Thus Moyo (2010) correctly opine that the republic seems less obliged to undocumented migrants and that for this group to claim entitlement on Section 27 is putting a stake on ambiguous and blurry provisions. In clearer terms, the provision by the constitution is in reference to those who can legally make claims to these provisions. Being without

documents constitutes an illegality and those illegally in the country cannot make legal claims on Section 27 of the Constitution.

The National Health Act (NHA) 2004 is next in queue in guaranteeing access to health services for all. Section 5 notes, 'A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.' (Department of Health 2004: 20). The Department Of Health Memo (Department of Health, 2007) highlights challenges in all provinces regarding access to treatment by patients who do not possess the South African National identity document and therefore stipulates that no patient should be denied ART because they do not possess documentation. The Gauteng Department of Health in April 2008 (Gauteng Department of Health, 2008) echoed the same sentiment by means of a memo stating that no patient should be denied access to any health care services including ART based on possession of the republic's identification document.

A Revenue Directive from the National Department Of Health in 2007 addressed to the Provincial Health Revenue Managers (HIV/AIDS Directorates) cites the Refugee Act, Act No. 130 of 1988 (Chapter 5, Section 27, (g)) (Department of Home Affairs, 1988) as its preamble. The Act states that a refugee is entitled to the same basic health services which the republic's citizens receive from time to time. It further states that refugees and or asylum seekers with/without permit that access public health care services are exempted from paying for ART. Last the HIV, AIDS, and STI National Strategic Plans for South Africa (South African National AIDS Council, 2007, 2012, and 2017) are very explicit on non-citizen groups stating and upholding their right to HIV prevention, treatment and support. Therefore, from the above legal and policy provisions, it is clear that all in South Africa are guaranteed to access public health care services. However, existence of provisions does not translate to practical access. These are directives from central spheres of administration and whether and how these guarantees are implemented rests with the periphery i.e. the facility level and the front line staff. As I will discuss the decentralisation of the South African health system later, it will become very clear that existence of directives is not enough (Moyo, 2010; Maynard-Moody & Musheno, 2000; Walker & Gilson, 2004; Siddle & Koeble, 2013). Formulating and enacting policies and legal instruments respectively is but one pillar and aspect of the public healthcare administration. The human aspect i.e. that aspect that translates (or fail to) these provisions into practice is equally critical.

### 2.1.5 Tracking programmatic interventions on HIV/AIDS and STIs in South Africa

There is a vast body of literature that has tracked how policy on HIV in South Africa evolved over the years from the pre-apartheid period to date (Wouters & Van Rensburg 2010; Ngwena & Van Rensburg 2002; Fourie 2006; Schneider 2002; Grimwood et al 2000; Nattrass 2004). It is critical to pay attention to this work; and a critical analysis of the themes therein and a look at what justifies such focus on policy processes at the higher echelons of administration shows some ideological inadequacies that calls for a paradigmatic shift specifically on how policy and practice should be understood.

The literature which tracks national guiding documents on HIV/AIDS and STIs in the pre-1994 era observes weak responses to the epidemic primarily because the epidemic was emerging and mainly confined to men who have sex with men and bisexual population, and also because of the mistrust between the government and civil society owing to the illegitimacy of the apartheid government – a factor which hampered multi-sectoral responses (Van Rensburg et al 1992; Wouters et al 2010). The 1994-1996 period saw the ushering in of the National AIDS Plan (NAP) (renamed HIV/AIDS and STDs Programe in 1995) with inputs from the Networking HIV and AIDS Community of South Africa (NACOSA). Wouters and colleagues critique the policy based on its content, actors, context and process (Wouters et al 2010). They observe that the policy was over ambitious; overestimated the new democracy's absorptive capacity; that inexperienced administrators were presiding over the government evolving structures; and that the epidemic was confined to the narrow domain of health and diseases under the department of health (DoH) and this made the policy difficult to implement.

An analysis of the policies from 1998 to 2004, the period of president Thabo Mbeki and health minister Dr Manto Tshabalala Msmang, has one outstanding theme – a troubled relationship between the government and civil society due to divergent views on the aetiology and epidemiology of AIDS (Wouters et al 2007; Wouters et al 2010; Ngwena and Van Rensburg 2002). This body of literature also unpacks the heated arguments of the time between government and civil society (see Kalichman 2009; Geffen 2009; Buttler 2005; Nattras 2007 for further discussions on AIDS denialism and its implications on state-civil society relations). Of special interest here is the common component in this literature i.e. the

inefficacy of HIV/AIDS policy stemming from schisms between two critical players in the production of policy i.e. the state and civil society. A track of the policies from 2004 to date (the Comprehensive Plan 2004-2007; and the HIV/AIDS and STIs National Strategic Plans (NSPs) 2007-2011; 2012-2016; 2017-2021) shows an improvement in state-civil society relations. However, these improvements were under the auspices of litigation (Nattrass 2007; Bateman 2007; Wouters et al 2010).

Thus literature tracking HIV/AIDS programmatic interventions in South Africa focuses on policy making processes at higher levels. The assumption is that policy developed at the top will inevitably be implemented at the lower levels. There is preoccupation with agenda setting as opposed to whether and how these agendas translate into practice at the bottom. This presupposition is congruent to the basic tenets of first generation policy implementation researchers who assumed that 'implementation would happen 'automatically' once the appropriate policies had been authoritatively proclaimed' (Najam, 1995, p. 8). I argue that the literature that has been tracking programmatic interventions to HIV and STIs in South Africa predominantly focuses on the top-down approach in policy processes in which the starting point is the authoritative decision where centrally located actors are most relevant to producing the desired effect (Matland, 1995). Thus, even when scholars like Wouters, Van Rensburg and Meulemans (2010) endeavour to analyse the prospects of success of the National Strategic Plan of that time, they look at the content, actors, process and context within which the policy instrument came into existence. But can production of desired effect be accounted for from the centrally located actors only? I acknowledge that the HIV epidemic in South Africa was greeted by schisms between the state and civil society, a phenomenon which was topical hence warranting attention. If two critical players in policy practice are in a polemical relationship, that certainly warrants attention, and the literature discussed here did that.

Wouters and colleagues are congratulatory to the idea that the schisms between the state and civil society that marked the HIV policy landscape in South Africa have dissipated (Wouters et al, 2010). While such a development paints conviviality in policy formulation at the top, the question is whether what the top pronounces informs practices at the bottom. But perhaps the existence of local government in South Africa ensures the efficiency of centralised agenda setting i.e. formulation of policies. The adoption of decentralisation as a "politico-administrative and constitutional paradigm" in South Africa was premised on the view to

provide participative, democratic, responsive, efficient and effective government (Siddle & Koelble, 2013, p.33).

### 2.1.6 Decentralisation and local government in South Africa.

According to the United Nations (2009), decentralisation is a process of allocating financial and some decision making responsibilities from the central to the lower levels of government. Siddle and Koelble identifies three levels of decentralisation i.e. deconcentration, delegation and devolution (Siddle & Koelble, 2013). Deconcentration is understood as the allocation of policy making functions by the central government to lower level offices (ibid). The central government still wields power over the peripheral office (Schneider, 2006) and national level policy remains the obligation of the national government (Oxhorn, 2009). Delegation involves a process whereby the local offices are given power to formulate policy but they remain accountable to the national government (Scheneider, 2006). Devolution is defined as the giving of decision-making and implementation power to the local government sphere (Kauzya, 2007).

Wide-spread as decentralisation is, applying these clear cut definitions in contexts where decentralisation is exercised proves a daunting task. South Africa practices decentralisation, yet it is difficult to compartmentalise it into one of the three levels identified above. This is probably due to the politics behind the embracement of decentralisation post 1994 in South Africa. Manor reminds us that most ruling parties in their struggle for self-rule succeeded by strategies which were central planned. These successes 'naturally inclined the new leaders to the view that further great accomplishments were likely if they could maintain unified efforts by centralised, homogenous means' (Manor, 1999, in Siddle and Koeble, 2013. p 18) i.e. centralisation. Many (for example De Viser, 2005; Wittenburg , 2006; Friedman & Kihato, 2004) concur with Manor, postulating that the South African anti-apartheid movement was predominantly centralist and in its view, the movement was steeped into the idea that a central state was necessary to undo the apartheid injustices and effectively combat inequality and poverty. Thus the African National Congress (the biggest nationalist group) got into the 90s power negotiations with the view of a unitary state responsible for delegating power to subordinate peripheral administrative units (Siddle and Koeble, 2013). To that end, while

South Africa embraces decentralisation in a *de jure* sense, practically the framework straddles and borders between delegation (the lesser level of decentralisation) and centralisation.

South Africa is complex such that the delegation of authority to lower levels is sometimes hybridised with centralisation. A top-bottom approach in policy processes still has space in the South African space. Even if the South African decentralisation framework was in line with the ideal definitions of the concept; decentralisation as a concept still borrows from the tenets of the top-down model of policy practice. The transference of responsibility to provinces inherently supposes that what is decided in these spheres where power has been delegated is supposed to inform practices at the lowest levels. Thus provinces or municipalities are the framework within which other institutional arrangements (districts or sub-districts) are nested. To that end we can say decentralisation is a disaggregation and disbandment of centralised top-down model (the central government) into smaller, numerous top-down models in which the new top (the province or municipality) is supposed to guide practices in the extreme periphery (sub district, village or family).

Yet others (for example Steytler, 2003) will argue that sub-national units influence national policy, thereby positing a bottom-up approach. Steytler refers to the era in South Africa when the national government was pressured by 'dissident' provinces to provide Nevarapine (prevention of mother to child transmission drug) and AZT (anti-retroviral therapy drug) to the public with the Western Cape Province being the lead dissident (ibid). It will be myopic to argue against such empirics, but it is also crucial to note that the bottom-up approach here was via litigation and coercion – it was out of the ordinary. Interestingly however is Steytler's observation that in South Africa, national legislation prevails over provincial laws even on matters falling within the province's exclusive jurisdiction (ibid). Thus it is safe to say that the prevailing policy practice in South Africa is located within the top-down model in which the upper levels of governance are naturally and logically expected to command practices at the lower levels yet it is at these local levels that realities are experienced on the ground.

### 2.1.7 The South African governance structure: the health system

The South African health system is decentralised. Scholarship (Gilson, Morrar, Pillay et al, 1996; McIntyre & Klugman, 2003) discusses the fact that since 1994, the republic's health system was decentralised. It is observed that the health system was affected by two parallel processes of decentralisation i.e. devolution and deconcentration (Gilson, Morrar, Pillay et al, 1996: McIntyre & Klugman, 2003). These scholars define devolution a creation of quasi-federal governments below the state (provinces and local government) or the creation of sub-national tiers of government and deconcetration as a process when administrative authority is conferred to locally based offices of a given government department. According to them, this process occurred simultaneously with devolution i.e. the South African government created provincial health departments which further created health districts and regions in some provinces. McIntyre and Klugman notes that the creation of districts and regions was before local governments were consummated constitutionally hence there are blurred and confusing boundaries between these districts and local governments. It is further noted that the confusion is further exacerbated by the fact that whilst these health districts are a vie for autonomy and decision making at the district level, there remains management structures for formerly vertical health programmes eg SRH programmes were once centrally coordinated and the central managers at both national and provincial level still remain to 'engage' with district and regional managers created with the advent of deconcetration (ibid).

Confusing as decentralisation in South Africa is, the point is that the health system is decentralised. Whilst policy formulation on health constitutionally sits with the National Department Of Health, it is observed that various spheres of government are consulted and have input, and it is observed that these spheres have a legitimate interests in contributing to policy since it is these spheres primarily considered domains of implementation hence feasibility of policies is of much concern to them (McIntyre and Klugman, 2003). For example, the Provincial Restructuring Committee (PRC) (heads of the national and provincial health departments) and the South African Local Government Association (SALGA) meet monthly to discuss policy and implementation issues (ibid).

However, planning, financing and management of the South African health sector in practice largely remains top bottom in nature. The same paper by McIntyre and Klugman (2003) highlights this fact. It is noted that district and facility managers feel excluded from the process. Managers are quoted saying the process 'It's totally top down' and 'This is the policy from national and you have to implement it' (p. 111). Furthermore, fiscal decentralisation is nothing but a continuation of vertical planning. Whilst government spheres

below the national make budgetary submissions to the province and national tiers, the lower tiers have been seen complaining about their submissions not being considered and the upper tiers make claims that budgets from below are unrealistic hence they cannot be taken into account in allocations (McIntyre , Thomas , Mbatsha, et al 1999). In other words, allocations are arbitrary much to the disdain of the lower levels. Therefore, while constitutionally the South African health system is neatly and ideally devolved and deconcentrated, practically the centre holds ie central planning and programming reigns supreme. It is then not an exaggeration to conclude that the system is top bottom which warrants investigation of how the bottom fares with and perceive directives and distributions from the centre.

It is also worrying that in a country like South Africa where there is significant population mobility and incidences of communicable diseases (SADC 2009; Vearey 2014; Matjila et al 2008), there is no specific department that is responsible for managing migration in the country. Movement of people between provinces and healthcare facilities is not regulated. The issue of migration is mainly managed by the Department of Home Affairs and this management is from the standpoint of erecting barricades and strong borders. It is correct to say that the current South African healthcare system does not engage with population mobility in any way. While migration should not be exceptionalised, it is crucial to consider that the circumstances under which migration occur and the possible challenges that human mobility creates if not considered in governance structures are worth considering if South Africa seeks to have a healthy population.

### 2.1.8 Non-Governmental Organisations – State partnerships in healthcare provision

There is overwhelming consensus about partnerships between the state and non-state actors in the provision of services, particularly primary healthcare globally and in Africa (IOM, 2008; Acharya et al 2017; Gilson et al 1994; Bratton, 1989; Batley, 2010; Loevinson and Harding, 2005; Schneider, Hlope and van Rensburg 2008). The focal points of scholarship may differ according to context and discipline, but all cited scholars congregate around the observation that partnerships between the state and non-governmental organisations (NGOs) has become the mainstay for service provision particularly in resource deprived contexts. For example, on one hand Acharya and colleagues (2017) focus on need for analysis that considers partnering

institutions in both high income and low income settings; whilst on the other hand Gilson and colleagues (1994) focus on investigating the empirical justification of the efficacy of NGOs. Yet despite the different area of enquiry, both studies find common ground on the fact that NGO – State partnerships are effective means of service provision notwithstanding the challenges associated with such partnerships.

A compelling case is made as to the inevitability of NGO – State partnerships in service provision, particularly in the health sector. The IOM in 2008 lists a number of grassroots NGOs among whom are religious organisations that are directly involved in providing various services to migrant populations who either are in transit or live in the Mussina border town of South Africa (IOM, 2008). Acharya et al (2017) state that while the state is the underwriting authority on the health of a country's citizens and has the prerogative of developing and implementing policies at the national level and coordinating various stakeholders that have a stake in the health sector; the state usually lacks resources and management challenges. They state that the challenge of funding in the public sector may see the state ignoring and depriving priority to critical areas in the health delivery system. The same is echoed by Loevinsohn and Harding who aver that the most consequential factor in improving primary health care delivery is the roping in of non-state players since the state lacks the efficient use of resources (Loevinsohn & Harding, 2005). More so, Gilson argues that the relationship and proximity of NGOs to the areas they service is the chief source of the efficacy. Such discussions also permeate the late 20$^{th}$ century literature in public administration (for examle Asamoah-Bah et al, 1992; Muijinja et al, 1993).

These observations do not however negate the importance of the role of the state in ensuring that NGO-state partnerships work. Many of the scholars cited above except Bratton (1989) and Batley (2006) acknowledge the role of the state in the delivery of primary health. Bratton and Batley largely focus on State – NGOs partnerships in terms of tension and acrimony (Bratton 1989 & Batley 2006). While underscoring the importance of NGOs in service delivery, Acharya et al maintain that any intervention that does not include the state risks seeing NGOs running parallel programs which are detrimental to fragile low income setting health systems (Acharya et al, 2017).

However, the applauding of State-NGO partnerships should in no way imply a rosy union between these two players. It is observed that these partnerships are not an easy go since the government is not always willing to engage NGOs which are donor driven, have little

responsibility as far as accountability is concerned and their operations usually qualify as competition as opposed to collaboration with the state (Acharya et al, 2017). The matrix of funding is also said to have a bearing on State – NGO collaboration – different sources of funding means different and multiple sources of influence and allegiance on the part of the NGOs (ibid). Bratton sees these collaborations as highly political whereby the state is always in pursuit of control whilst the NGOs are constantly seeking autonomy from the state (Bratton, 1989). Batley shares the same sentiments arguing that non-state actors are not in close dialogue with the state and the relationship between the two is marked with mistrust (Batley, 2006). Thus as regarding State-NGO collaborations, there are three common themes: the necessity of collaborations; the challenges facing these collaborations owing to differing perspectives of the actors involved; and the challenges facing the state in delivering health services on its own.

## 2.2 The Study's intellectual site: Framing the study

A detailed section on theoretical framing will follow. At this stage a snapshot of the theoretical tools that framed this study are given. I draw from the Institutional theory (Scott, 2014), which is a conceptual framework for understanding organisations, social structure and the associated individual behaviour. It is key in the understanding of individual behaviour vis a vis social structure/institutions; aiming to unpack what determines the behaviour of individuals in an organisational setting. I also use Lipsky's (1980) street-level bureaucracy which posits that the practices of workers of agencies constitute policy, not an abstract policy document from an unseen figure. It also states that the working environment in an agency has an impact on how the agency workers practice their duties, a factor which has implications on how policies translate into practice. The research question and objectives are nested within these theoretical frameworks.

## 2.3 Research Question

**In what ways do interventions involving state health facilities and NGOs consider migration and how does employee behaviour influence whether and how services are provided to migrant populations in Makhado, South Africa?**

In answering this question, this study will seek to answer the following sub-questions:

1. What are the knowledge, beliefs and views of nurses on migration and migrants and how do these influence whether and how they provide primary healthcare services to migrant populations?

2. What are the factors within and outside the work environment that shape these beliefs and perceptions?

3. What are the factors that influence grassroots NGOs to providing services to various populations and do these factors influence whether and how services are provided to migrant populations?

## 2.4 The study's physical site

The Margaret Pyke Trust and European Union provided funding to three grassroots NGOs in Vhembe District, Limpopo, South Africa. These are Thohoyandou Victim Empowerment Project (TVEP); Thsilwavhusiku Victim Empowerment Project (TsVEP); and Vhumbanani Peace Building Project (VPBP). The first two focus on SRH, Gender Based Violence, minority rights among other services related to these thematic areas. The latter focuses on programmes that aim to curb and stop anti-foreigner sentiments that result in xenophobia. These NGOs were working in collaboration with state departments mainly the Departments of Health, Justice and the Police. The funding's main deliverable was to expand the

geographical reach of these projects. The broader project in which this study is nested aimed at evaluating if the funders' deliverables were being met. This study specifically focused on whether these programmes were reaching migrants and whether the behaviour of the employees of the organisations involved and other service providers could be used to explain the manner in which services were provided (or not) to migrants.

### 2.4.1 The Makhado local Municipality

According to the Local Government Handbook of municipalities in South Africa, there are extensive commercial farms in Makhado involved in pawpaw, nuts, litchi, pineapple and mango production (http://www.localgovernment.co.za/locals/view/132/Makhado-Local-Municipality#map). Hall and colleagues document the existence of a well-established history of migration into and through Limpopo from Zimbabwe, Botswana and Mozambique (Hall et al, 2013). They also document how the economic and political crises in Zimbabwe since the 2000s precipitated a wave of migration that has seen the Limpopo province hosting a significant number of migrants. In their study on farms (Makwembe and Malamba amongst others) in the Vhembe district, they reflect that much of farm labours in the district are foreign immigrants, with Zimbabweans constituting 80% of the labour force on these farms. Buttressing this reflection, Skjaeraasen (2008) quotes a farmer who reflects on how the Limpopo River (the natural barrier between South Africa and Zimbabwe) provides them with water and Zimbabwe with labour. As stated in the background of the study, Limpopo province in which Makhado is located is home to a significant population of Zimbabwean nationals who are either in transit or have decided to stay there owing to how this place is closer to home (IOM, 2008; Africa Check, 2006). Whilst a greater proportion of migrants in this region are in farms, a considerable number stays in villages and towns in this region doing various jobs including cleaning houses, running small businesses and any odd and manual jobs that they can get.

# Chapter 3

# 3 Theoretical Underpinnings

## 3.1 Institutional Theory

Institutional Theory has served, since the mid nineteenth century to date, as a conceptual framework for understanding organisations, social structure and the associated individual behaviour. The theory, according to Scott (2014) addresses 'provocative questions about the world of organisations' (p: xi). These questions include why organisations in different contexts exhibit nearly uniform attributes; and how should behaviour in organizational settings be understood i.e., whether it is a reflection of the pursuit of rational individual goals or a reflection of deeply imbibed institutions (conventions, culture, norms or mores). More so, the theoretical approach addresses why the behaviour of actors in organisations departs from formally and clearly stated rules; where interests stem from (are they natural to humanity or are socially constructed); and the fact that if institutions are a dictate for human behaviour, what then is the place of the individual in the construction of institutions?

Institutions are defined by W. Richard Scott as '…regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life' (2014, p: 56). Thus they are structures of social order within which individual behaviour finds meaning. According to this definition, institutions have a broader social purpose whose intentions and purposes transcend personal interests in their ability to mediate rules that govern behaviour. This theoretical approach has overwhelming and dense debates since its inception with economists (for example Scholmer 1900-1904; Menger, 1983 & 1986; Veblen, 1898 among others, in Scott 2014), political scientists (for example Tocqueville, 1856; Burgess 1902, Woodraw Wilson, 1889), and sociologists (Herbert Spencer 1876, 1896, 1910; Cooley, 1902, 1956; Marx, 1844) attempting to explain individual behaviour in relation to social institutions. Unpacking the intricacies of these debates is beyond the scope and practicalities of this study, but suffice to say is that all scholars acknowledge institutions, with the major point of discussion being whether social structure (institutions) are a given-a priori, an epistemic ally objective social fact, or whether

'individual' behaviour structure institutions. This is a variation, or rather a reflection of the eternally abiding agency –structure debate. Is human behaviour rational and individualistic? Is rationality really out there (epistemically objective)? Maybe rationality (individual purpose) is bound by social structure i.e. institutions. These are issues which Emile Durkheim grappled with in which he perceived institutions as an assemblage of individual habits (Alexander, 1983) and later on perceived institutions as social facts which are objective and coercive to the individual (Durkheim 1901, 1950).

To make these dense discussions more palatable, allow me to borrow Scott's (2014) analytic framework in which he uses differences among institutional scholars to enact three pillars that constitute institutions. These are regulative, normative, and cultural-cognitive pillars. Each pillar reflects how scholars understand institutions. These pillars are 'principal dimensions along which assumptions vary and arguments arise among theorists emphasizing one or another element' (Scott, 2014, p. 59).

### 3.1.1 The Regulatory Pillar

Many scholars (Worth, 1990; Skocpol, 1985; Tolbert & Zucker, 1983) gather around this pillar. The main premise of this orientation is the directing of human behavior by coercion, rules, and laws. Conformity is based upon seeking rewards avoiding punishment (Scott, 2014). Thus, scholars who rally behind this conception of institutions see formalized structures and mechanisms as paramount in explaining human behavior and conformity. These scholars do not deny rationality, but they argue that the seemingly human rational decisions are framed within coercive mechanisms in which individuals subscribe to the notions of instrumentality – people do what they do because they are calculative rational beings who seek to maximize benefit over costs. Benefits are in the form of profits (in business) and costs are in the form of punishment (the long arm of the law). A review of the institutional literature shows that this orientation lends itself to an instrumentalist view of social life, a view espoused in various Economists' works on institutions. This view leans much to structuralists' arguments which are castigated by Sewell (1992) in their assumption of causal determinism in life; yet, the notion of instrumentality discussed in this literature defeats the directing of human behaviour through coercion. While this view of social life

seeks to posit structures as impervious, primary, hard and immutable; agents are presented as knowledgeable entities that have the capacity to navigate coercive mechanisms.

However, Scott (2014), while acknowledging symbolic systems (laws) powers to regulate behaviour, he is of the idea that these symbolic systems relate not only to substance, but to affect (emotions). He avers that rationality, or codified norms which are a premise upon which the regulatory pillar stands, is not the only driver of decision making; emotions also stand as one of the most motivational aspect of social life. More so, when coercive institutional demands are in disagreement with individual demands (see Creed, Dejordy & Lock, 2010 on identity conflict), emotions are said to drive 'actors to change institutions to which they have become disinvested' (Scott, 2014, p. 63). Laws can be abolished and constitutions amended. While Scott and colleagues are making meaningful contributions, they are not really positing a new idea because instrumentalism has got human agency at its core. The meaningfulness of their contribution is in explaining instrumentalism better rather than introducing a new thought.

Scott states that recognition of emotions in the regulatory pillar will privilege work at the micro level – the individual. He stresses this by observing that even those rules backed by enforcing mechanisms can be defied and confronted. Conformity is not an inevitable response, but only one of too many possible responses by those subject to regulatory powers (ibid). Therefore, it is evident that even within a single pillar; there remains the bigger debate between the macro and micro - the debate on which sphere stands as reality. This speaks to broader issues of ontological foundations of each perspective. At a more sophisticated arena, the regulatory pillar stands at a lesser level of creation of reality, at least according to Scott. As Searle put it, the pillar sees human behaviour and roles as 'epistemically objective' (1995, p. 1; 11; 13) facts in the world. Actors are seen as a priori; a reality really out there, and can thus, through rules, be influenced and affected as they follow their interests. The regulatory pillar is preoccupied with affecting and influencing 'antecedently existing activities' rather than focusing on the creation of certain activities (ibid, p. 27). Simply put, this pillar privileges the macro against the micro level. However, Durkheim would argue with Searle and confront him on criticizing the normative pillar as perceiving the individual as an objective fact in the world. From a Durkheimian perspective, the pillar rather sees norms as social fact, an objective reality with the capacity to influence human conduct. To further engage with these questions on ontology will hoists this discussion onto a platform of elitist philosophy. Suffice to say is that the pillar places value on structures external to the

individual: the individual is a rational being but raw materials to exercise this rationality are found in social structure.

### 3.1.2 The Normative Pillar

Around this pillar congregate scholars emphasizing normative values/rules that introduce prescriptive, evaluative and obligatory dimensions to life (Scott, 2014). Under the 3 'i' framework (Garvin, 2014), the normative pillar would fit in the third 'i' (institutions) in which institutions are conceived as formal or informal rules, norms, precedents, and organizational factors that shape behaviour (Hall & Taylor, 1996). Levi speaks of 'path dependence' where an organization's past policies shapes subsequent political dynamics and policy options. These notions buy into 'institutionalization of organization' where by organizational practices are institutionalized to become an institution in themselves (Selznick, 1948) with the capacity to dictate human conduct. Organisations are changed into institutions. Selznick argues that 'institutionalization of organizations' is a process, and it reflects an organization's own history, the people once in it with the interests they created. Thus the scholars reify organizations/structure (a Durkheimian perspective); they are seen as entities that acquire identity and a distinctive character that moulds human conduct. Scott (2014) analyses it in a clearer way; that as organisations embodies particular values, they acquire a ''character *structure*' (Durkheim's Social Facts), a distinctive identity', thus organizations 'are no longer …expendable tools; participants want to see that they are preserved' (p. 24). In that case, Weberian bureaucracy lends itself to both the regulatory and normative pillars of the institutional theory. The weakness of this view is an implication that the interests of actors previously in the organisation have a spell on present actors. Just like the regulatory pillar, it is not analysed how individuals create reality, but how individuals are affected by a social reality created by their predecessors, and these predecessors' social reality was also created by their predecessors…and so on. The possibility of present actors actively creating their own social reality is negated. To be more problematic - what about organizations without predecessors? However, my analysis here is more subjective; the analysis sounds much like one coming from the corridors of Giddens' Structuration theory (1976, 1979, 1981 and 1984) in which a balance between structure and agency is the focal point.

More so, a glorification of the pre-eminence of social structure affords hyper stability to structures which makes discussions on change, adjustments and compromises even more awkward (Sewell, 1992). There is bias towards Bourdieu's habitus in which his ideas

ultimately maintains structural determinism. Sewell however refers to Bourdieu as a combined determinist since Bourdieu posits that structure and agents reproduces one another such that even the cunning actions of agents reproduces structure (Sewell 1992). This is a matter of semantics, the crux and pith of the issue is that structure is given prominence. Such arguments and discussions perhaps points to the eternal agency-structure debate; and chances are high this debate will never be settled because the case of where one stands reflects their ontological orientations. In the depths of the discussions of structure and agency sits the question of which sphere (structure or agent) is really real because that which is real has a spell on the one with secondary or superficial existence. But then, which of the two is real? Are they even real? Is one real apart from the other or they have a communal or shared reality? What is reality? This will drive us back to philosophical discussions on ontology. It is productive at this juncture to eschew such dense discussions and conclude that the normative pillar affords reality to structure whilst relegating agency to spheres of secondary-superficial reality dependant on the girders of structure.

### 3.1.3 The Cultural-Cognitive pillar

The focal point is shared conceptions that constitute the nature of social reality and also create frames by which meaning is made (Scott, 2014). This pillar is more appealing in that first, it recognizes external influence to behavior, and second, it acknowledges that between external stimuli and response, there is an internal representation of the world – the cognitive aspect, hence the hyphenated label ‘cultural-cognitive’ (ibid). It is therefore no secret that scholars who gather here are moderate in their view on source of identity formation, self-conception and self-consciousness. To them, the self is a product of both structure and agency. Anthony Giddens and his Structuration theory are at home here. While this approach tend to bind human behavior in social systems (culture) (the stress that orthodoxy influences behavior), it operates at a higher ontological level than the preceding pillars (Scott, 2014). By privileging cognitive processes, the approach speaks on the construction of social actors i.e. how roles come by and the subsequent decision making. Regulative rules only seek to regulate socially constructed reality (Scott, 2014). According to Schneider (1976), norms and rules (to which the normative and regulatory pillars lend themselves) engage with patterns for action and how to play the scene, whilst constitutive rules (to which the cultural-cognitive pillar lends itself) engages with deeper level of reality creation. As said by Scott ‘constitutive

rules (cultural-cognitive) construct the social objects and events to which regulative rules are applied' (2014, p. 77).

I use the preceding theory to investigate what factors lead local level organizations to provide services to certain target populations including migrants. Organizations are a crystallization of human beings. Governmental policies, dictates and recommendations are structures (they are codified norms and formalized beliefs and values). The same applies to organizational rules and norms and funder interests. Therefore, understanding how individuals in an organization come up with and implement a program is an act whose meaning is worth finding. The investigation of what is done by an organization and how it is done within the framework of the Institutional theory helps in the understanding of the source of interests and motives of philanthropists. Are local level organizations, NGOs to be specific, influenced by government policies and recommendations (institutions/structures/codified norms and beliefs)? Are they aware of them (these structures)? What is the position of the organisation on funder interests vis a vis theirs? These organisations also work with state facilities like clinics and it is useful to adopt this theory to analyse how this relationship works and whose interests take centre stage.

## 3.2 Street level bureaucracy

Street level bureaucracy is a concept in the public administration circles that gained ascendancy in the later part of the 70s with the work of Michael Lipsky. Street level bureaucracies are workers of public institutions who practically interact with users of government services at the point at which these services are delivered (Lipsky, 1980). Street level bureaucrats are thus the workers of these public agencies (nurses, teachers or police men) who are in regular direct interaction with recipients of government services, and they have power to exercise a degree of discretion over services, benefits and sanctions received by their clientele (ibid)

### 3.2.1 The theory's key thesis

The centrality of Lipsky's street level bureaucracy (Lipsky, 1980) is the idea that 'decisions, actions and practices of street level bureaucrats actually 'become', or represent the policies of the government or agency they work for' (Erasmus, 2017.p 1)). This stems from the fact that the citizen (or recipient, for Moyo (2010) states how the 'citizen' is a contested space that includes citizens as well as migrants in the South African space) or client of state services is the one who 'directly experiences' (Erasmus, 2017 p. 1) what the government offers on paper albeit through what the frontline employees of the state facilities do in practice (ibid). Hence policy (or de facto policy) is the benefits or sanctions meted on clients by workers of any agency. Policy is not written text by some official sitting somewhere in lofty government towers. Policy is practice.

The common theme in literature on theories on bureaucratic procedure (for example Taylor and Weber) is the presentation of employees as passive (Moore 1987; Moore 1990). Albrow posits that Weberian analysis of organisations sees relationships among staff members from a point of the giving and receiving of orders (Albrow, 1970). However, Moore is of the idea that street level bureaucrats are inventive (not passive), and have the capacity to navigate and negotiate ambiguous work settings (Moore, 1987). This is in line with Lipsky who avers that since street level bureaucrats are professionals expected to exercise judgement in their field of expertise; and since they have relative freedom from organisational overseeing agents; and since they perform tasks too complex to be reduced to script or formulae; they end up 'making' policy in different (sometimes unexpected and unwanted) ways.

Discretion can therefore be defined as choices by street level bureaucrats on how to exercise power in the performance of their daily tasks (Maynard-Moody & Musheno 2000). Being the last level in the policy development processes tier, street level bureaucrats' work is involves discretion (Kelly, 1994). Thus the tradition to which the street level bureaucracy theory lends itself (the bottom-up approach) is in line with the imperatives of this study i.e. to understand policy development from the bottom, or to see practices at the bottom and periphery of central or local government processes as policy experienced by recipients of state services. Understanding policy development processes from the bottom-up perspective has also been hailed by many (Walker & Gilson, 2004; Weissert, 1994) who assert that policies are created and recreated by the street level bureaucrat.

Many factors account for the behaviour of the street level bureaucrats discussed above, and these include, as discussed by Ermin Erasmus (2017) in his analysis of Lipsky's theory:

#### 3.2.1.1 Lack of resources

This constitutes lack of resources and understaffing. The street level workers may become overwhelmed by tasks assigned to them and may sometimes be inexperienced to perform certain tasks, and culminates to a stressful environment which makes it unrealistic for them to stick to abstract directives on paper.

#### 3.2.1.2 Lack of clear goals

Vague, ambiguous and conflicting goals, for example a programme may have conflicting ideas which were never resolved in the designing stage of that programme, or there may be organisation practise of sticking to goals which the organisation never had time to evaluate and if necessary, drop them (linked to path dependency (Levy, 1997) (Erasmus, 2017). This may result in street level bureaucrats exercising discretion by doing what they think is practically viable.

#### 3.2.1.3 Providing services to clients who have no immediate alternative sources

State facilities are usually the only providers of services they will offering in many contexts (Erasmus, 2017). This is said to affect street level bureaucrats' commitment to service quality and client satisfaction. Thus the street level bureaucrats are in a position of power and control over their clients. Hupe and Hill (2007) concur arguing that street level bureaucrats have access to resources which their clients do not have, and this by implication suggests that the power scale is tilted in favour of the service provider. Others (Maynard-Moody & Musheno, 2003; Kelly, 1994) characterise the relationship between clients and bureaucrats in terms of unequal or asymmetrical power relations in which the latter is better positioned.

# Chapter 4

# 4 Methodology

The table below is a summary of the objectives and methods used in the study and below it is a detailed discussion of these methods.

| **Sub-Research Question** | **Method used** |
|---|---|
| 1. What are the knowledge, beliefs and views of nurses on migration and migrants and how do these influence whether and how they provide primary healthcare services to migrant populations? | • Semi-structured interviews with operational managers/nurses in charge and nurses of the local clinics<br>• field notes |
| 2. What are the factors within and outside the work environment that shape these beliefs and perceptions? | • Semi-structured interviews with operational managers/nurses in charge and nurses of the local clinics<br>• field notes |
| 3. What are the factors that influence grassroots NGOs to provide services to various populations and do these factors influence whether and how services are provided to migrant populations? | • Interviews with the management of TVEP, TsVEP and VPBP (the grassroots NGOs involved in the project)<br>• Taking field notes |

## 4.1 Introduction

In order to understand whether and how local level interventions consider migration and whether the behaviour of employees helps in explaining whether and how services are provided to migrant populations; the researcher used different qualitative research methods. These are formal semi structured interviews, informal interviews and conversations with the participants taking field notes. It was necessary to use these different methods because some of the participants were evidently not comfortable to divulge information they considered sensitive in a formalised interview setting especially with the recorder turned on. This section gives a detailed explanation of the methods used, the summary of the actual research process, study site, ethical considerations and limitations of the study.

## 4.2 The Study Site

This study aimed to understand the factors that determine the behaviour of public health care workers when providing services to the migrant clientele. It also sought to understand factors within and beyond the organisational sphere that influence grassroots organisations to provide services to certain populations including migrants and to see whether and how issues like funding and state policies are factors in these organisations' philanthropic endeavours. To make sure these questions were answered, I situated the research in an area with a fair amount of migrants and community organisations and clinics that work within these areas to provide services to various populations including foreign nationals. The research was therefore done in Makhado town and in the Kutama-Sinthumule area - namely in Midoroni, Tshilwavhusiku and Madombidzha villages. The community organisations investigated are Thohoyandou Victim Empowerment Project (TVEP); Tshilwavhusiku Victim Empowerment Project (TsVEP); and Vhumbanani Peace Building Project (VPBP).

## 4.3 Research Participants

Below is an inventory of the research participants. Some of the names are pseudonyms in order to protect the identity of the participant since some of the information they offered was

sensitive according to theme and they divulged it after the researcher's guarantee that anonymity and confidentiality will be pursued by all means possible.

| **Name of Participants interviewed** | **Name of facility or Organisation** | **Position in facility or Organisation** |
|---|---|---|
| Masikwa | TVEP | Acting Director |
| Ellen | TVEP | Manager-ZTA |
| Tapiwa | TVEP | Manager – Monitoring & Evaluation officer |
| John Sadiki | TsVEP | Director |
| Pastor Joseph Maphosa | VPBP | Deputy director |
| *[1] | TVEP | Legal Officer |
| *Oncology nurse | Louis Trichardt Hospital | Nurse |
| *Nurse 1 | Midoroni Clinic | OP/Nurse in charge |
| *Nurse 2 | Midoroni Clinic | Nurse |
| *Nurse 3 | Tshilwavhusiku Health Centre | OP/Nurse in charge |
| *Nurse 4 | Tshilwavhusiku Health Centre | Nurse |
| *Nurse 5 | Tshilwavhusiku Health Centre | Nurse |
| *Nurse 6 | Madombidzha Clinic | OP/Nurse in charge |
| *Nurse 7 | Madombidzha Clinic | Nurse |
| *Nurse 8 | Louis Trichardt Hospital | Nurse |
| * | TVEP | Finance Manager |

[1] The participants were not at liberty to disclose their names and the researcher took heed of that.

### 4.3.1 Health Care Providers / Street level bureaucrats

One of the goals of this study was to understand the views, beliefs and perception held by nurses on migration and migrants and how these influence the choice to provide (or not to) services to migrants and how these services are provided. The researcher treated operational managers and other nurses as frontline workers because they all have physical contact with the patients. By health care providers I mean individual practitioners in clinics and hospitals.

### 4.3.2 Grassroots Management

These are the people classified as managers and the directors of the organisations in question. It was also the objective of this research to understand factors that influence NGOs to provide services and whether these factors influence whether and how services are provided to migrant. The need to understand what influences what these organisations do (i.e. their interests and goals) could only be sufficiently explained by people who are in the decision making echelons of these organisations because it is these people who set the path that the organisation pursues.

Some of these organisations were very small such that a series of interviews with one figure (the director) in the organisation was sufficient to fulfil the needs of the questions being asked. These small organisations were TsVEP and VPBP and the researcher relied on a series of interviews with their respective directors and the data elicited was rich to generate themes from it. In case of TVEP – the bigger stakeholder – the researcher did interviews with managers of the departments in the organisation.

## 4.4 Selection of Participants

The researcher engaged in a purposive procedure of identifying participants as done by Moyo who did a study similar to this one in some aspects (Moyo, 2010). Purposive procedure according to Legard et al. (2003) is a process where participants are selected depending on what the findings are as the research progresses. The researcher selected some participants based on, for example, the recommendations of an organisation's director especially when some of the questions required a figure with expert knowledge in the area. This was the case in TVEP where the director would refer me to managerial figures with knowledge in finance and legal issues within the organisation.

## 4.5 Research Instruments

### 4.5.1 Interviews

The researcher used semi-structured interviews and informal interviews with both the grassroots management and the public healthcare workers. Formal structured interviews were very useful in providing insights into the thought processes of the participants and the institutional sphere and circumstances from with these thoughts and the ensuing practices are drawn (Hammersley & Atkinson, 1983) Interviews with public health care professional were all conducted on the second visit from 18 September to the 29th of September 2019. The interviews were with 9 nurses, all females, 3 of whom were operational managers commonly known as Nurses in charge. The interviews with the management of the grassroots organisations were conducted on the first field visit in June 2018. The interviews with health care providers were conducted during times when some of them were free in some cases or after the operational manager created space to be interviewed. The researcher was provided with an office in each facility to conduct these interviews and he requested to be with the interviewee only so that there would be no constraints and limitations to the information obtained from the interviewees. Some of the offices were the Operational managers' so the need would arise to politely ask the manager to vacate so that the junior nurses being interviewed will feel free to provide any information. In the case of the management of the community organisations interviews were conducted in offices, open spaces or in cars as long as it was convenient to the interviewee and researcher.

### 4.5.2 Conversations

According to Fieldman (1999) Conversations are oral inquiry processes, collaborative or long and serious conversations. The need for conversations arose from the fact that some issues arose during the research process which would not be on the interview schedule but are crucial in the answering of the research question. More so, conversations offered a less

formal setting and some interviewees said more and rich information during conversations than formal interviews. There were cases of two health care professionals who made sure the recorder was switched off first after the formal interview and henceforth they would elicit rich data crucial to the answering of the research question.

### 4.5.3 Field Notes

Field notes involved the researcher's reflections of each day in writing. After each day the researcher had long moments of reflections and interpretations of certain activities observed during the day. Some information and conversations would not make sense during the time they would have occurred but after long reflections and meditations sense would emerge and it was critical to put these reflections in writing after each day in the field. Sometimes writing down content of conversations would elicit fear and suspicions especially on the part of interviewees who loathed formal interviewees. In such cases the interviewee would have to listen attentively and later on regurgitate it on the paper.

## 4.6 Data Analysis

This study used Interim, thematic and comparative analysis

### 4.6.1 Interim Analysis

According to Becker (1971) processing data in qualitative methods which make use of interviews is an on-going process and data is analysed as the research progresses. At the end of each day the researcher had time to listen to the recordings and go through notes on conversations so as to find the need for adjustments or expansion in the collection of data and to determine if the findings are speaking to the primary units of the study. Interim analysis allowed the researcher to generate preliminary themes and identify shortfalls or gaps in the questions on the interview guides in accordance with Pope, Ziebland et al. (2000) who state

that interim analysis affords the researcher time to adjust questions and identify areas in need of further inquiry.

### 4.6.2 Thematic and Comparative Analysis

Thematic analysis began right from interim analysis where interim or preliminary themes were generated from the data collected. Comparative analysis involved comparing and contrasting data from different participants, which according to Tere (2006) should be done up until a point where the researcher is sure that no new themes or information is generated i.e. point of saturation. The researcher compared data from different health care providers and also from the staff of the community organisations until there were no new themes and information being generated.

## 4.7 Practical and Ethical Considerations

In interacting with the interviewees, the researcher considered anonymity and confidentiality. Anonymity in that the researcher will not collect identifying information (names, addresses and any other individual specific information); and confidentiality in that responses given will not be connected to any of the respondents. This speaks to broader issues of the non-maleficence principle which upholds that both the researcher and participants are safe from harm at any stage of the research or after (Gabrium and Holstein, 2002). Some of the responses given by the street level bureaucrats were at variance with organisational principles and in defiance to clearly stated policies on conduct, a factor that may have implications on the relationship between management and subordinates. To mitigate for this potential harm, pseudonyms were used and the information collected was kept in password protected files.

However, anonymity could not be fully guaranteed, and this was made clear to the participants. The researcher explained that even with the use of pseudonyms some of the information provided can be linked to the participants especially in cases where the need

arises for the researcher to state positions of the participants in the organisation. This is the case especially with Operational managers because each facility has got one operational manager and it is easy to attach a name to the pseudonym the researcher might have used. Fortunately there was no ultra-sensitive information generated that put the participants in any danger.

The researcher followed ethical procedures by applying for ethical clearance from the non-medical research ethics committee of the University of the Witwatersrand – protocol number H17/08/23. The researcher also applied for and was given clearance to enter the public health care facilities form both the Limpopo provincial health department (Appendix 8) and the Vhembe district health department (Appendix 9). In the case of the community organisations, the researcher also applied for and was granted permission to conduct interviews within their premises (Appendix 10).

The researcher informed the participants about the scope of the study and that it was strictly for academic purposes. The researcher explained to the participants about the potential risks in participating in the study and the fact that there were no foreseeable immediate benefits for their taking part in the study. Having explained this, the researcher asked the participants to append their signatures on the written informed consent forms accompanied by the participant information sheet. Interviews were conducted in a manner that would not significantly disturb the work of the participants. In cases of clinics the operational managers arranged an office and invited a nurse whom they knew was not busy at the moment. In the case of community organisations, the directors also arranged meetings between the researcher and the interviewees.

## 4.8 Limitations of the study

The main challenge which contributes to the weakness of this study is that whilst the research questions were being developed, it was done within the context of pre-existing broader project. This presented a challenge and temptation of twisting research questions to meet the

deliverables of the broader project. The researcher was aware of this and he avoided the temptation by consulting a large body of literature so that the study would have a more scholarly complexion. More so, the researcher could have also interviewed migrants to get the other side of the story because interviewing nurses only focuses on one side and readers and the researcher are denied a full picture of the interface between the migrant patient and the healthcare provider. Participant observation would have been another way to correct this. However, the researcher was not able to correct these issues due to time and budgetary constraints since the facilities were significantly distant from one another.

Nevertheless, the study is still very useful in that academics from different disciplines can still engage and converse with the study since the researcher made sure to make the theoretical frameworks the core discussants of the findings. Literature speaking to the research or empirical element of the study (migration) was also a discussant of the findings but not to the extent gone by the literature on the theoretical front. It is crucial that a study gives pre-eminence to the intellectual site so that the study becomes more relevant beyond the empirics of migration studies. Therefore, the effort the researcher put in making the theoretical frameworks major discussants on the findings makes this study very relevant beyond the discipline of population mobility.

# 5 Chapter 5

## 5.1 Factors influencing grassroots organisations to provide services to target population

### 5.1.1 Introduction

This chapter reports on findings generated from interviews and conversations with the managerial staff of TVEP, TsVEP, and VPBP. Three themes emerged from the study as the researcher sought to understand the factors within and outside the organisational sphere that influence grassroots organisations to provide services to certain populations, and whether migrants are included and why, and the way in which these services are provided. First it emerged that a perpetual or everyday presence by these organisations within the communities in which services are provided is one of the key factor that informs and motivates them to provide services and shapes the way these services are provided. Second, even if funding is crucial to the operations of the organisations, a common thread that permeated the study is how organisational goals which reflect the organisational actors' cultural orientations serve as a yardstick against which funders' demands, expectations and deliverables are examined, winnowed and accepted or refused. Last, it emerged that the organisations are not significantly influenced by the state since they seek to pursue goals that are consistent with the cultural schemas and resources of structures and institutions that the organisational actors are exposed to. Thus, cultural orientations of the people involved in an intervention is one crucial way of understanding what is done, why it is done and how it is done.

The findings and discussions presented below owes much to Institutional Theory as it proves to be a very useful tool in understanding behaviours of organisational actors as they pursue goals and interests which can be fully understood within the auspices of the ever abiding discussions on structure, duality, agency and change. Ultimately, as evidence will show, community organisations seem to be only influenced by ideals that are consistent with cultural schemas from institutions within the social system the organisations are located in.

But before the themes are discussed, the context within which the organisations operate in and the scope of the services provided are explained first.

### 5.1.2 Context and location of the grassroots organisations - Makhado and Kutama-Sithumule

This section is a prelude to the findings. Before I get deep into the themes generated in the study, this section offers to explain the context of the study and the scope of the work that is done by the actors involved, particularly the community organisations. After this task, the following chapters will then serve as platforms for the discussion of the findings.

Kutama and Sinthumule are under Makhado municipality and home to a series of villages. Of interest are villages I did research in namely Madombidzha, Tshilwavhusiku and Midoroni. From Madombidzha to Midoroni through Tshilwavhusiku is approximately 15 km. These villages are home to migrants especially from Zimbabwe, Mozambique and the horn of Africa. In case of Zimbabweans it is so because the Zimbabwe –South African border is approximately 100km from this location. In my discussion with Pastor Joseph Maphosa, the deputy director of VPBP, and John Sadiki of TsVEP, they stated that there is a fair concentration of migrants in the Kutama and Sinthumule but not compared to Makhado town. Here is what Pastor Maphosa said regarding the statistics of migrants in the target area:

> *Our projects target both nationals and non-nationals. The non-nationals are mainly from Zimbabwe, Mozambique, Ethiopia and Somalia. The intention is for them to get all the services they are entitled to by the South African government. In Makhado Zimbabweans are many. They are plus/minus three hundred households, not individuals here in Tshikota alone. There are many others in Newtown, Makhado, Madombidzha, Sinthumule and Kutama. Mozambican numbers can be bigger than Zimbabweans. Somalians and Ethiopians are slightly lower because they go into the interior of South Africa. Also their profiles differ. Ethiopians and Somalis like to do projects like buying and selling whereas Zimbabweans do different work like building,*

> *construction, some are in teaching and some like women they are working in local houses as maids.* (Interview, Pastor Maphosa, Vhumbanani Peace Building Project)

While this statistic is sketchy, it gives one the idea that this geographical location is home to immigrants. This is consistent with what the IOM and Africa Check observes (IOM, 2008; Africa Check, 2006) stating that Limpopo is home to many Zimbabwean national who are employed in various low paid jobs. As in Kutama and Sinthumule no one could give an elaborate estimate as Pastor Maphosa did for Tshikota. However in the interviews nurses gave a vague estimate stating that migrants are many in the area. They actually used the word 'many' and others gave estimates that migrants may constitute 25 % of their patients. This perception without concrete evidence will be discussed in the following sections as it speaks to broader issues of how health care professionals' perceptions influence their interactions with migrants in their facilities.

### 5.1.3 The scope of services provided by the grassroots organisations and its structure

TVEP is housed in Thohoyandou, a town 70km from Makhado. It is a community organisation that that focuses on providing prevention, empowerment and support services in five thematic areas namely child abuse, domestic violence, HIV/AIDS, sexual assault and LGBTI/minorities including migrants. The organisation has got trauma centres in hospitals in Thohoyandou and they focus on counselling among other services to victims of abuse or rape. TVEP operates in Thohoyandou and Makhado – within which are Kutama and Sinthumule area. The organisation has got more than 20 fulltime salaried employees and has got a director responsible for each thematic area. It is these directors that the researcher interviewed in order to understand what informs what they focus on. The ultimate purpose was to understand whether and how the state among other players like funders influence the drawing of and fulfilment of the thematic areas they have dedicated themselves to pursue.

Here is what Masikwa, TVEP Director, said regarding the scope of his organisation's work:

> *Our mandate is to address issues pertaining to sexual assault, domestic violence which also incorporates IPV (Intimate Partner Violence), child abuse, HIV and AIDS stigma. We also deal with minority groups; these are your sex workers, your foreigners and your LGBTQI. Now we have also expanded to cover sexual and reproductive healthcare rights. So we say we act in accordance with our six thematic areas because all the issues are interlinked; you cannot address one and not address the other one. Then at least when you address all these things you are able to uproot even the root cause because what we have realised is that oftenly we mop the floor while the tap is still open. So what we are trying to do is to first close the tape then we mop the floor. So that's why you know our interventions in three forms: response, support and …also empowerment like for example you do not expect someone who is not empowered to exercise his or her own rights so we first go to the community, we workshop them on their rights….We have also been working with three circumcision schools for over a period of five years and I am telling you the results are amazing* (Interview, Masikwa)

Pastor Maphosa said this regarding the scope of the work done by VPBP:

> *The reason why this organisation exists is to assist the community with information that is relevant to its day to day way of life be it health or services which can be rendered to them by the government. This organisation was formed around 2008 in response to the xenophobia violence and here in Tshikota there were some incidences of violence and our organisation worked to bring peace by having dialogues with the community members. We no longer have serious incidences of xenophobia here. We have now also expanded our work into various areas of service provision and as you see we are working with TVEP which means our area of focus has expanded* (Interview, Pastor Maphosa)

John of TsVEP also explained the scope of the work of his organisation and how they came to work with TVEP:

*Our organisation deals with various issues in disadvantaged communities as you can see that our community is disadvantaged. We deal with gender based violence, orphans and vulnerable children, minorities which include the gays and foreigners. So you see this TVEP, we heard about them some few years ago and because our work is almost similar we went to learn from them. There were a number of projects which they were running which need to empower the community. And then we partnership with them but* (and) *when they got funding from EU they came back to us they said we worked well before we need to partner with you. Can you identify for us two problematic areas which you see in your area and one must be the most disadvantaged community which we did? We gave them Madombidzha as the problematic area and them Midoroni which is the most disadvantaged community. (Interview, John)*

* * *

## 5.2 'We know what we talk about': Interventions kindled by empathy, volition and emotions.

*Chonoziva ivhu kuti mwana wembeva anorwara*

It is the soil that knows that the offspring of the mice is sick (Shona adage)

In this section evidence is submitted to the effect that the community organisation's (in this study) work is motivated by their own observations of what ills the society. I will also submit that closeness to or living within the communities by grassroots NGOs is an ingredient that feeds into their motivations to engage in interventions of various sorts. The interviewees coalesced around the idea that they are self-motivated in their endeavours and they saw their interventions as more effective than those done by the state. Scott (2004) and Sewell (1992) will be used as an intellectual platform in theorizing what emerged in the interviews. NGOs interventions or principal goals are a reflection of a socially constructed reality and shared identity with the communities within which they operate. Through interviews with the management of the different organisations in this project, the researcher observed that NGO officials believe their approach to projects is more effective compared to the government's. Interviewees conceived of their successes in juxtaposition to the inadequacies of the state. In interviews, the researcher noted that NGOs generally view the state as incompetent. Whilst the NGOs were working with certain arms of the state, it was clear that projects targeting migrants and other populations were not in regard to any policy or centrally or locally coordinated programmatic interventions. Rather, the programmes were a result of the organisation's own will and discretion.

During the interviews, the interviewees made it clear that grassroots organisations are constantly on the ground and in contact with the communities they work in. All the organisations I worked with were very clear that they feel they are more effective than other players, particularly the government because of their abiding and everyday presence in the community. They pride themselves in their ability to be with the people every time. Here is an excerpt of my conversation with John, TsVEP director:

***Q**: What influences what you do as an organisation and what is the place of the state in these projects?*

***A**: According to my research* (my observation) *we as the civil society are the foot soldier. They are down on the ground…but when you start they were no were to be found* (the government) *because there are a lot of social workers but the social workers are not the foot soldiers they are just there in the offices…waiting for...people to come to them. They don't go to the people* (interview: John)

There is emphasis on being on the ground; being with and within the people; and being foot soldiers. But important to note is also the fact that the interviewee could not highlight the success of the civic society without demeaning government operations. The same approach is seen in Masikwa of TVEP:

> *We are community organisations. We know what we are talking about. It's not like somebody who is seated in the national office who has never have communications with the real victims. Every day we are talking to different victims we are having dialogues…workshops…meetings so it is very simple for us to have an understanding of what is happening …* (Interview: Masikwa)

Pastor Maphosa of VPBP also weighed in stating how community organisation are cognisant of how and when to approach the communities with various projects. He reiterated that community organisations are not haughty in their approach as they go on the ground, and according to him this is one of the factors which make their projects more successful than those done by state actors. What he said was also backed by the fact that this interview was actually conducted in Tshikota village at a school where they were having a dialogue with

Zimbabwean migrants. Here is what he said when I asked him what influences what they do as an organisation and why he feels their projects are more successful:

> *What we do is in response to what we see on the ground. We see the needs of the people. Just to name a few what we have done. People used to stay for more than two weeks without water and we had to engage the local leaders, chiefs…we realized that it ended there until we even have to engage the minister and people managed to get water…so it is in response to what we see on the ground.*
>
> *In my visits to hospitals I have realised that foreign nationals are neglected and they are not given full information. So we do what we do because of what we see on the ground. This is one of the reason we engage other stakeholders like TVEP who also see things like we see. Such organisations come for free to the people and they make time tables which are so conducive to the participants. Things are done at the community level like we have done now…and these people* (he refers to TVEP) *they don't look at themselves like they are so special. They come down to earth and want to interact with the people. So when people get information from such a person they normally respect and take it seriously* (Interview, Pastor Maphosa).

Having brought up the issue that they engage the government in certain instances for example the crisis he mentioned about a community that had to go for two weeks without water, I sought to know if government policies and recommendations affect what they do as an organisation. Here is an excerpt of the conversation:

> **Q**: *Do government policies and recommendations on certain issues affect how you do your planning as an organisation, if yes, to what extent does it affect or influence you?*

> **A**: *No it doesn't affect. We do according to what we see. It only affects if we try to engage with some higher offices to say can you see that there is a need then they ignore. That's when we feel its effects because we live with the people and we stay with the people. We really see what the people go through unlike those people who just come up with policies they put it at* table then they go *away. They don't exactly know what is happening down here. But we see.* (Interview, Pastor Maphosa)

The above shows that grassroots organisations hail their everyday existence in communities they work in. So, when grassroots organisations do work in communities it is from their knowledge of what happens in the communities. As seen in the interviews, this knowledge comes from being 'on the ground' and living with the people. Literature demonstrates that the efficacy of NGOs in service delivery is as a result of among other factors, a constant exposure to target communities (Acharya et al, 2017; Batley, 2006). While this contributes to effectiveness of what NGOs do, Batley and Bratton points out that this is one of the sources of a toxic political relationship between NGOs and the state since NGOs may feel they are more important and in touch with the community than the state (Batley, 2006; Bratton, 1989). This is correct in this instance. It is evident that the individuals I interviewed could not speak of their success stories without highlighting the failures and shortcomings of the state. Nevertheless, it still remains that whatever influences community organisations to do what they do derives from what they see on the ground owing to their closeness and presence in the community. They know. It is knowledge that is internally generated and their philanthropic acts are an obligation to this knowledge.

A common thread that permeated the interviews and conversations which the researcher had with the leadership structures of the community organisations was a constant repeat of the phrase 'we realised'. This 'realisation' is a product of being within the community. There is a Shona adage which goes '*chinoziva ivhu kuti mwana wembeva anorwara'.* Loosely translated it means it is the soil which knows that the offspring of the mice is diseased. The deeper meaning is to the effect that the soil, being in perpetual contact with the mice in the burrows, is always in the know of the fate that befalls these burrows' residents. Just like the soil, the community organisations are perpetually in contact with the communities and the realisations and knowledge they have is an inevitable result of this contact. Here is what Tapiwa, the

monitoring and evaluation officer of TVEP said regarding their projects on migrants after I asked him why they focus on migrants as one of the population groups targeted by their interventions:

> *The other thing is we realised that there were incidences of xenophobia and as an institution we found the need to address that. What we also realised is that with immigrants, service providers will also take advantage of them because they are undocumented…even if something bad happen to them they will never go for services because they are afraid that maybe they be deported. We work with community structures…We are in the community working with the community for the whole year just to sensitise people on all these aspects. There are migrants in in the community and we invite them to have dialogues…we listen to their concerns. We even go to the extent of dealing with controversial topics and at the end of the day you know you even see the chief demonstrating (the use of) female condoms and male condoms so we see this project is really working* (interview, Tapiwa)

It is crucial to interrogate this knowledge and frame it intellectually. Can we say that agency is manifested in this knowledge? After all, according to Giddens (1981 & 1984) knowledge and ability are two crucial components of agency. We say 'knowledgeability' (knowledge plus ability) to refer to the capability of humans to engage in rational activities. In that case then one can say it is knowledgeability (agency) of grassroots organisational actors that influences and propels them to provide sexual and reproductive health services to various populations. It is very correct to say so, but even more correct is to seek to understand the content of such knowledge in an intellectual sense.

When people say 'we know', what is it that they know? What is the content of such knowledge that other actors like the government do not have. Sewell digs into cultural anthropology and explains that while humans are knowledgeable – they possess knowledge and ability, what people know is culture (Sewell, 1992). Culture is the content of their knowledge. He argues that human resources (knowledge and emotional commitments) are a consequence and manifestation of cultural schemas. Sewell's intellectual orientation on

agency in relation to structure informs Scott's 'cultural-cognitive pillar' in which he explains human cognition (knowledgeability) in cultural terms (Scott, 2004). Therefore when the organizations' actors said they know and understand, they profess to their cognitive capacities or virtual human resources (emotion and knowledge) which are however texts from which cultural schemas are reflected (Sewell, 1992). The cognitive capacities are writings from which we recover structure.

In light of the above, organisations are driven by their own human resources (knowledge and ability) which are however embodied in and instantiated by cultural schemas. If human resources are an instantiation and representation of cultural schemas and ideals, then human innovativeness and knowledgeability find meaning on the edifice of structure. The community organisations' actors do not possess any knowledge apart from the one oriented on the social structures that create and model this knowledge. This helps in arriving at the understanding that interventions and projects done by NGOs in this study are on the greater part characterised by social commitments and obligations to social sentiments and socially structured reasoning as opposed to any other influences exterior to these social orientations.

The interviewees also stated that this is not to say that the government is not doing anything. For example Ellen, a manager in TVEP responsible for Zero Tolerance Alliance (ZTA) that works with schools as Zero Tolerance School Alliance (ZTSA) and with villages as Zero Tolerance Village alliance (ZTVA) said,

> *I can say as the organisation yes we have the impact that we are making in the community even the department* (government departments) *but because tina* (us) *we are full time in the ground and unlike the departments where they will go maybe after there are some cases or whatever but tina* (us) *it is our work to work on a daily basis in the community we are able to identify the issue that is happening before the department can discover that so I think if we have to compare the two I think the organisation is the one* (that is effective) *because sometimes tina* (us) *when we get the information ....but I can say all of us have impact because sometimes we have things as an organisation we don't have control where we will need their intervention* (interview, Ellen)

Yet, while acknowledging the importance of the government, it is clear that Ellen had no doubts in her mind that civic society has more impact due to its perpetual presence. All of the interviewees echoed the sentiment that the government wants people to come to them to get services while grassroots organisations go to the people. According to them, the government is elitist in its approach since its workers want to work from offices. They admitted that some of the government policies are good but they lack implementation. Pastor Maphosa stated that they are:

> *The reason why we have engaged this TVEP is like the government, yes, of South Africa, I have realised that it's one of the government that have very good policies but lacks implementation. The government workers do not want to interact with community members like we do. You see that I live here in Tshikota and we are doing projects here. The people here know me and respect me. I understand what the people suffer because I live here. I don't come and go. But the government like clinics or hospitals it is the people who have to go there and the workers only know the problems by being told. When people suffer xenophobia attacks for example, I don't need to be told because I live here and I can relate with what they will be saying. We see what the people go through because every day of our life we spent it in the community* (Interview: Pastor Maphosa)

To them, the government lacks contact with the people. It is important to note that government here is not only perceived as unknown people in offices somewhere. As seen by the example of social workers given by John previously, government is perfectly understood in all its tiers i.e. from the executive down to the 'street level bureaucrats' (Lipsky, 1980) who are stationed in community facilities. Whilst a government facility might be in the community (clinics and magistrates for example), they are seen as very near yet so far. It is the people that go to the clinics and courts to get health and justice respectively; but grassroots organisations go to the people, and live with the people. So the government is seen only in terms of crafting abstract policy documents and shelving them, or if it decides to implement, it is from the comfort of the office. Thus, the government in all its forms is seen as withdrawn from the people though in most cases its facilities will be right at the door steps of those in need of these services. These factors dovetail with what literature on State-NGO

partnerships say; scholars observe all the shortcomings of the state that came up in these interviews and it is upon this basis that calls are made for partnerships (Acharya et al 2017; Gilson et al 1994; Bratton, 1989; Batley, 2010; Loevinson and Harding, 2005; Schneider, Hlope and van Rensburg 2008)

However, what emerged from this study demands a focus beyond a call for partnerships. The fact that the state and NGOs have partnered is not enough to ensure efficacy in service delivery. As seen in the work of Bratton (1989) and Batley (2006), the state may partner with NGOs yet this does not necessarily mitigate for animosities that exist prior to this union. Animosity might be too strong a word to characterise the relationship between the state and NGOs in this study, but it clear that there is a general contempt of government efforts. Whether this contempt is justified or not, what is evident is the fact that there is mistrust that exist between these two players and as will be discussed later in this section, this hampers prospects for coordinated efforts where the NGO compliments the shortfalls of the state. The NGOs in this study were surely working with state but only as far as using its facilities and making sure they hold the government to account. The underlying determinants of what the organisations were pursuing could not be traced in the tenets of this coalition.

The sentiments of high regards for self by the organisation continued to permeate the interviews. Here is my interview with TVEP legal officer:

**Q**: *You have said that you feel your projects are more effective because they are people driven. Do you mind explaining further what you mean by that?*

**A**: *Oh yes! What you have to understand neh* (you see) *is that TVEP is an organisation that is based in the society. When we do our things we do them because we understand what we are talking about and saying. Before, people were not getting quick justice on rape cases and gender based violence. But because our work we managed to engage the government departments like the prosecution* (Prosecution Authority) *to speed up progress and victims are now getting justice very quickly. You should understand that the people respect us for that because they see us as saviours. When we see each other you can see that things are happening which were not happening before. Even*

> *people with other legal issues now want us to help them but we say no we only deal with survivors of rape and gender based violence. My friend, the respect we have is big. We love these people and they love too…very much. Yes there are challenges here and there but…love is everywhere. We are brothers* (with the community members) *and this make our work easy. That's why you see that it is even not difficult for us to get volunteers in various projects it is because the communities understands us very well* (interview, TVEP legal officer)

Living with the people denotes being one with them. Their constituency is not a distant entity. They (the organisations) are based in the very same community they seek to assist. The emphasis on 'staying' and 'living' with the people gives them an experiential knowledge. Before they react to any problem, the problem is first felt from within. Scott (2014) states that between external stimuli and response, there is an internal representation of the world. This internal representation is the frame by which meaning on social predicaments is made. Predicaments exist within the organizational actors as they do not only live with people, but live those very problems. They do not imagine 'being in the shoes' of the victims; they are perpetually in the shoes. This is empathy. There is affect and emotion. Below are extracts from the interviews I did with Pastor Maphosa and John respectively:

> **Q**: *So you have a big attachment with this place?*

> **A**:*…Learnmore* (interviewers name) *it was very tough this xenophobia thing. You* (could) *see that people wanted blood because on TV the people were seeing what was happening in other places like Joburg* (Johannesburg) *for example and Durban. But we as organisation stood very string to say* (to the nationals) *you see that we have been living in peace before what has changed now. I could feel the anger and hatred some of the people were showing. But because people respect me the situation was contained. We have respect here my guy. Another thing is you see some say why foreigners own house here? I have a house here in this location and some did not like it that a Zimbabwean owns a*

> *house. But I have a permanent res* (residence) *in South Africa and the law allows me to have property because I am a permanent resident who is legally here. So when I stand to stop these things* (anti-foreigner sentiments) *I know what it feels like because I am also a victim. But I am happy that there is some peace now though there are still some problems. For example we had booked to use the community hall for this migrants' dialogue but there were others who made noise* (quarrel) *that why is the event only for foreigners. You know the thing is they think we will be giving people things like money and food so there is some anger there. So we ended up asking to use this school where we are today because I have some very good relationship with the headmaster and some of the teachers here. You have to have some connections for things to work* (Interview: Pastor Maphosa)

Responding to the same question John said:

> *You have seen that almost everyone in this community knows me when I was showing some of the houses of people I work with. Do you know that some people even think I am a police officer because I am always with the police doing issues of rape and violence in this community? I have been living in this for a very long time so I* (know) *what happens here. It pains me to see that some childrens sleep in dongas* (dilapidated non-inhabited houses) *and you see very young children being raped. Some people are very evil ey. You see it is easy for me to do this work because I know every corner of this place from Midoroni where we went in the morning to Madombidzha* (interview, John).

From the above, when VPBP wants to address xenophobia in all its forms, it is from experience and emotion. He himself is a Zimbabwean national presiding over an organisation that seeks to address institutional and non-institutional xenophobia meted on foreign nationals. He lives in Tshikota Township in Makhado, a place that houses many foreign nationals, mainly Zimbabweans. So we have a Zimbabwean who lives the experiences he seeks to mend. He lives with the people and lives their (which is his) problems. The same

goes with John (TsVEP Director) who lives in Madombidzha in Tshilwavhusiku. John is not a Zimbabwean like Pastor Maphosa but interventions they provide are products of their experiences and observations, not in response to state mandates and stipulations. Their experience and knowledge are stipulations and mandates in themselves. If state/government policies coincide with their objectives, it is mere happenstance. So pastor Maphosa (VPBP) and John (TsVEP) do not 'go' to the community with programmatic interventions, they live in the community with their interventions. These are interventions riding on a wave of emotion and affect – attributes of cognition or cognizance. It is these emotions that crystalizes and sediment into thematic areas or goals and objectives of their respective organisations. While possessing these attributes proved to be a big driving force in interventions that were done, the worrying thing is the insecurity and unpredictability of trusting emotions and human volition to determine what gets done and how it is done especially in addressing migration. Pursuits of goals while riding on the wave of emotion and will puts potential recipients of services at the mercy of these unpredictable elements of the human mind. If human will and emotions become distorted, and it is likely to do so especially in the field of migration, the fate of recipients of services hangs in the balance. There is need for interventions to be coordinated such that the outcomes of such efforts rest on explicitly stated guidelines and policies or else local level interventions will just mirror the stance of the Republic on migration which fails to explicitly and unambiguously address, for example, population mobility (Vearey, Nunez, Palmary 2009; Moyo, 2010).

NGO management saw it as an affront to their ethos when external players feel they can arm-twist them using financial or political clout to pursue objectives than are not aligned to their interests, volition or observation. Masikwa of TVEP said:

> *...that's why you see that eh it is very difficult when we come to issues like funding. Sometimes funders be it the government, because we also get funding from the government, or western donors in Europe. They want certain deliverables which you relly know these are not the real (exact) things we see on the ground. We really know issues on the ground and you see that funders are just people seated in Europe they don't have real picture and it is upon us to advise them…so we negotiate with them because we are the ones in the*

> *bush here we really know the things that happens in these communities* (Interview: Masikwa, TVEP Director)

Masikhwa sees it as his organization's responsibility to give direction to any player that seeks to correct the wrongs in the society his organisation is domiciled in. To pursue any interests or goals at variance with their thematic areas is to cast a shadow over their identity and cognitive capacities. To expend their goals is to expend their very self. Organizational goals have become an embodiment of particular values that '…are no longer …expendable tools; participants want to see that they are preserved' (Scott, 2014. p. 24). This continues to show how community NGOs are spirited in their campaigns and projects, yet this potentially has the capacity to derail and undermine contributions by other actors, and when the other actor is the state then Batley's observations are substantiated that the state blame NGOs for their untenable pursuit for independence and propensity to run parallel programmes (Batley, 2010).

When Masikwa says, '...they don't have real picture…' he uses very rich metaphorical language worth of analysis. If external entities don't have 'the picture' then Masikhwa's organisation (and the other two) has it. What is this 'real picture'? It is the everyday experiences of the communities they live and work in; experiences that are embodied in their thematic areas or organizational goals. Therefore, by 'they don't have the real picture'; Masikwa means external players don't know their pain, predicaments and grievances. The organisations in question therefore cannot be influenced on how to address themselves or issues that pertain to their self. They see themselves as the major stakeholders in the business of dispensing relief to themselves. They are physicians healing themselves. It is this viewpoint that Batley (2010) and Bratton (1989) say creates a feeling of dislike between NGOs and the state because usually the former sees the latter as an entity that usually runs parallel projects. From evidence being submitted here it is clear that NGOs seek and are proud of their autonomy from the state and that their obligation and commitment is not to the state (Bratton, 1989; Batley, 2006).

The understanding of the problems in the society is effortless for the organisations on the ground. They are in perpetual proximity to these problems. TVEP is domiciled in Thohoyandou; TsVEP in Tshilwavusiku; and VPBP in Makhadho town. For TVEP to work in Tshilwavusiku (Kutama-Sinthumule area), they relied heavily on TsVEP which is located in that area. The same goes with VPBP which TVEP relies on when they are doing

interventions in Makhado town. The reason for these organisations working together is through mutual respect and understanding that an organisation placed in a certain locality is better positioned to co-ordinate activities to be done in that place. During the field work, there was a time when TVEP organized a dialogue with migrants with the purpose of conscientising them about their sexual and reproductive health rights in Tshikota Township in Makhado. Pastor Maphosa of VPBP was heavily involved in making sure that the people attended. While TVEP had personal and material capital for the weeklong event, VPBP had social capital. The coordination was seamless and one would think it was one organisation involved. More interestingly, John of TsVEP was also instrumental in the coordination of the event. The researcher was amazed why the director of an organisation that is about 30km away from Tshikota was hands on the project. The researcher therefore asked why this was the case and whether such interactions will not create tensions or affect the identity of his organisation. In response, Pastor Maphosa stated;

> *No it does not affect, what happens is that we come together and no one will realise that I come from a certain organisation. We are working as a team. We are working as a family…We are working hand in hand without any challenges.*
>
> *One of the facilitators Mr Sadiki* (Director of TsVEP) *is the treasurer of VPBP whilst I am the secretary general* (Deputy Director)*. So it dovetails nicely without any challenges* (Interview, Pastor Maphosa)

This effectively blurs the lines between these organisations and ensures a seamless implementation of the projects. Whilst TVEP is based in Thohoyandou, 70 km from Makhado; TsVEP and VPBP have no problems in working with them. They see TVEP as another version of their organisations and the feeling is mutual. I asked Masikwa about why TVEP roped in other community organisations and whether this doesn't affect the objectives and goals of his organisation. He had this to say:

> *Haha those ones we are one with them. You see even the name TsVEP…is almost just like ours. I know that Thohoyandou* (where TVEP is housed) *is about…is it 80km from Makhado but when we are doing our work it's just like we are also from that community. The thing is we understand each other very well because we are all on the ground. It is like what they say* (public domain language) *that we speak the same language. I also think that because we have been working together on other projects and that makes us trust and understand each other very well. We learn from each other because one organisation* (each and every organisation) *has a speciality and we take advantage of that. We learn many things from each other. You will find when you go out on the migrant dialogue we have in Makhado that we work very well. You will think we are one organisation. Team work is very important in this work. You cannot do all of the things on your own and it is working very well* (Interview, Masikwa)

The above extract shows oneness and unity of purpose. The organisations, by these synergistic relationships, develop a shared meaning of reality. The Cultural-Cognitive pillar, one of the tentacles of Scott's (2014) conceptualization of Institutional theory, emphasizes on the shared conceptions that constitute the nature of social reality and also create frames by which meaning in made (ibid). Meaning is made via a sharing of conceptions. VPBP and TVEP have a shared understanding of social reality. With the communities they work and live in sharing physical boundaries, they also share social boundaries. Boundary here should not be understood in terms of physicality and difference. The Pastor's response shows that physical boundaries do not in any way cast in doubt the sameness of their communities. These societies have a shared understanding of reality. Therefore, if two communities share reality (self-conception and self-consciousness), they have a shared identity, or a shared self. So, when the Pastor looks at TVEP, he is gazing at himself. This is a somewhat reflection of Coley's Looking Glass Self i.e. an identity that derives from one's interpersonal interaction within the context of society (McIntyre, 2006). He is looking at another part of himself. The preceding explains how three apparently different organisations in different communities work seamlessly and see themselves as one. With NGOs working seamlessly together, the question arises that cannot this nature of relationship of trust be cultivated between NGOs and the state so as to create to possibility of more coordinated responses that are not fuelled

ad determined by what an individual actor see fit? If not, then these seamless unions between fellow private sector actors will more or less create formidable alliances, but against the state which is supposed to be a key player in coordinating responses that feed into national objectives.

The above presentation has two major things that are useful in understanding grassroots NGO interventions in the community. First, NGOs that operate from the community have a perfect understanding and a clearer picture of the problems they seek to address. They also have a clearer understanding of the recipients of those services. Secondly, despite this knowledge and understanding, NGOs, while they may have an honest opinion, view government's efforts as marred with inefficiency and ineffectiveness. This, as seen in the interview excerpts, leads to NGOs feeling less obligated to what the government stipulates. This relationship or viewpoint is very unlikely to change overnight but inroads can be made to make sure that the best is harvested from that relationship in its state. Interventions that seek to target migrants require coordination. What the researcher observed is that the NGOs in this study targeted migrants not in response to coordinated programming from the government or unambiguous and explicit policy on migration, but based on what they feel is the need at that time. These programmes are evolving from the context on the ground not from external influence. While this may be helpful as some of the individuals in the organisation have sentimental connections to migrants as was the case with Pastor Maphosa, this might not be the case in every interventions. Thus one might say local level interventions target migrants but such efforts are not coordinated and the target populations are at the mercy of the feelings, will and observations of the service provider.

## 5.3 Organisational goals as institutions: Ability of NGOs to navigate the politics of funding

> *Wherefore, my brethren, you are dead to the law…; that you should be married to another…. (Romans 7:4; KJV)*

This section shows that organizational goals (thematic areas) are 'social facts' (Dhurkeim, 1938) that regulate actors' behavior as they navigate the terrain of funding that by all indications has the potential to derail the interests of the funded. Since one swallow cannot make a summer, this section, while dealing with implications of funding, strengthens the case developed in the preceding section. I will argue that while community organisations demonstrate independence of sorts from funder organisations, this independence is made possible by their allegiance to other institutions i.e. organisational goals. This section argues that while the navigation of the funding terrain may seem to be a manifestation of individuality or an individual 'self', there is no 'self' but a social one, one that revolves around socially set parameters. If there is the existence of the individual mind; it is only in relation to other minds with shared meaning (Mead, 1982). Organisations exercise knowledge-ability and innovation as they seek to avoid the lordship of funders, but this innovation is influenced by and in keeping with social structures sedimented in organisational goals. Evidence will be submitted proving that organisations are constantly being policed by 'social facts'. All seemingly individual innovativeness is within the confines of set parameters i.e. organisational goals. Social facts (normative values and precedence) and 'path dependency' (Levi in Selznick, 1948) are powerful in prescribing appropriate behaviour (Scott, 2014; Garvin, 2014; and Hall & Taylor, 1996). While, through evidence, making a case of structurally determined behaviour, the essay will attempt not to present institutions as engendering stasis. Ultimately, this section will hopefully demonstrate that no-matter how organisations seek to be independent of funders' hegemony (a structure of sorts); they only successfully do this premised upon their dependence and acceptance of the lordship of another system i.e. organisational goals.

How is it possible to gain financial assistance from players who do not have a shared conception of reality with your own – players who are of different schemas (norms and

values) and resources (human i.e. knowledge and emotional commitments; and non-human? Through empirical evidence and intellectual engagement, I argue that organisations are entities with social actors who improvise and innovate in structurally determined ways. Whilst acknowledging agency; the argument for socially or schematic oriented agency will be constantly upheld.

In ensuring that a desired end is achieved, organisations navigate and negotiate sensitive (sensitive because where monetary resources are involved everyone is on guard) areas like funding with the ultimate intent that the identity of the organisation is preserved. Throughout the research it was beyond doubt that organizational interests come first. Whilst an organisation might lack material resources to set its interests in motion, roping in other stakeholders that can fund these interests is an undertaking that involves various exercises and thought processes that ultimately ensure the objectives and interest of the organisation are pursued. When asked about the implications of funding in compromising organizational interests, TVEP director had this to say,

> *It's very funny we are not like other institutions who dance to the funders tune we just don't want to have projects for the sake of having money we want projects interventions that will be relevant to issues we want to address and to make sure that they are relevant to the beneficiaries to the members of the community that we are working with so that's why we try by all means that we align to our 6 thematic areas.* (Interview: Masikwa, TVEP Director)

'Trying by all means' to align funder interest to the thematic areas included letting go of potentially lucrative funding. Masikwa was adamant that,

> *...if they don't want then that's it we lose that funding.* (Masikhwa,TVEP Director)

The TVEP legal officer weighed in stating that the interests of the victims are at the forefront in any discussions. I asked him about funders' requirements Vis a Vis their interests as an organisation, and this is our conversation;

**Q**: *When you are implementing projects that have been funded by funding organisations, to who do you feel obligated when you are implementing these funded projects?*

**A***:* *We seek to satisfy the victim. You know if we were saying our legal unit is a shop we say client first, customer first, customer is always right… so we want to satisfy our beneficiaries to make sure they are getting best services…we are improving access to justice for them. We would rather be fighting with the departments* (of the government*) or anyone but on a good cause for the victim* (Interview; TVEP legal officer)

What is the source of such rigidity and imperviousness? With more than a decade of provision of services in Vhembe district, the organisation (TVEP) has six thematic areas that it focuses on, and these areas have created a path upon which the organisation should tread upon in all its endeavours. Anything out of this path is a threat to the reason why the organisation exists. The thematic areas are a dependable path. They are 'social facts' prescribing appropriate responses. The organization's past policies shape subsequent political dynamics and choices. Whilst the reason why the organisation exists are a set of precepts that have originated from those who formed this organisation, these precepts have been institutionalised to become an institution in themselves (Selznick, 1948). These precepts, values and goals, or thematic areas (as TVEP would call them), have become a regulative element that provide stability and meaning to the organisation (Scott, 2014). Any contribution to the organisation, whether materially or ideologically, is screened, winnowed, and judged using the thematic areas as lens. Players in the organisation are bound by the organisation. Therefore, organizational culture – which is the feature of social existence denominated as structure in this instance, manifests itself as a feature impervious to human agency or other institutions that are not part of the social system that denominate the practices of the

organisations in question. This concurs with Sewell's analysis that structuralists' arguments assume a rigid 'causal determinism in social life' (Sewell, 1992. p 2). He argues that those aspects of social life denominated as structure by structuralists assumes a primary, hard and immutable qualities that renders events of social life (what others might term agency) as 'secondary, superficial and mutable within 'hard' structural constraints.' (Sewell, 1992. p 2).

However, an analysis of Giddens' Duality of Structure provides a different view which rescues organizational actors from the notion of rigidity and immutability of structure. In his works, Giddens argues that actors are knowledgeable entities that have the capacity to construct structures hence his argument that structures are not mere concrete girders that place constraints on actors – structures are enabling (Giddens 1976, 1979, 1981, 1984). Knowledgeability assumes innovation. This marks a remarkable epistemological shift from Durkheim. The fact that organizational actors in TVEP defend an organizational position shows elements of knowledgeability and choice – they choose (and choice is preceded by knowledge) to defend a position. It involves agency to choose. They are able to locate objectives that are not in line with their thematic areas. After all, contrary funder objectives are structural in themselves hence a resistance by organizational actors to these denotes knowledgeability, ability and choice. Yet, the fact that such a choice is in keeping with an established position points us back to the imposing nature of structure or Durkheimian social facts. Actually, in Giddens epistemological orientations, it is not only schemas and rules (norms, values and traditions) that have a structure character; resources have the same character too (Giddens, 1984). What he terms resources include humans and their mental aspects (knowledge and emotional commitments). In arguing for the power of agents, he bestows character structure on them. Like schemas, he argues, human resources have virtual character that has the ability to fashion schemas. However, Sewell is of a different idea. He avers that human resources are manifestations and consequences of schemas (culture) (Sewell, 1992). He does not deny their value and power, but he argues that 'the determination of their value and social power is dependent on cultural schemas that inform their use' (ibid, pp 13). While such a conception takes us back to Durkheim in which human resources (emotions and knowledge) are not coequal elements of structure, Sewell escapes this trap. He posits that while human resources are consequences of schemas, schemas finds meaning in human resources and schemas are dependent on human resources for their reproduction. Thus he states, "If schemas are to be sustained and reproduces…they must be validated by the accumulation of resources that their enactment engenders" (ibid, 1992. p 14). That way

duality of structure is preserved. Thus Masikwa and all TVEP actors have agency, but their agency is in paying homage to structures. Sewell himself, after presenting human resources as active agents, he later states that agency is dependent on the nature of structures that informs the social world that an actor is located in (Sewell, 1992).

What can be also be deduced from the above interviews is that not only do NGOs claim and pursue autonomy from the state as observed by Bratton (1989) and Batley (2010); NGOs also seek independence from funder institutions by all means possible as will be seen below. While Batley states that the difficulty of state-NGO collaborations owes in part to the fact that NGOs have commitment and allegiances to other stakeholders like funders (Batley, 2010), it is clear from the interviews that this is not as straight forward as it sounds. When NGOs take funding, it is because it in one way or the other corresponds to the organisation's goals and, as will be seen later, if funder demands don't exactly match their goals they find ways to align funder interests with their objectives either by negotiation or by informal means. This is innovation in action. It is this understanding which needs to be taken into account when considering partnerships in service delivery. To explicitly say that NGO primary allegiance is to the funder is too simplistic and it creates a picture of organisations that are soft on funders but hard in their dealings with the state. Evidence here suggests that NGOs commitment is primarily their target groups, not foreign interests of the funders. While foreign interests are part of the deliverables, these interests are only foreign to the extent that they are the brain child of funders, otherwise the pursuit of these interests gain traction under the condition that they match the primary goals of the community NGOs. However, this should not be taken to mean that all NGOs exhibit this kind of independence from funders. But as far as evidence here is concerned, NGOs are complex configurations that have capacity to negotiate the politics of funding.

In the interviews, it also emerged that sometimes funders can adjust their objectives to align with those of the community organisations they will be working with. Practically, it is difficult to have cases where funder objectives are perfectly aligned with those of the funded. The need always arises for adjustments and compromises. John of TsVEP said;

> *Yeah. Some of them like one of the funder who used to fund us they have to change their objectives. As I have mentioned before it is because we are on the ground so we negotiate and advise these funders that this and this needs to be*

> *changed and this and this needs to be done. You see that's how it works* (Interview, John)

Ellen, a manager in TVEP responsible for Zero Tolerance Alliance (ZTA) that works with schools as Zero Tolerance School Alliance (ZTSA) and with villages as Zero Tolerance Village alliance (ZTVA) also gave an elaborate explanation of how funders align their objectives with that of their organisations. She said,

> *You find that tina* (us) *as the organisation we have to, like for an example our funder wants us to identify the domestic violence cases or maybe when we go to school we are going to school for the girls club but when we arrive there we are not going there to identify the cases*(only) *...but because we are working in that school each and every cases that they reported in the school as long as…we have the way of solving that issue it's either we refer or do whatever, but even if it is not part of the objective of the funder but what I like is that most of the things you find that it's not on the objective but as the funder they also realise gore* (that) *it's something important that will also make their organisation to be recognised because some of the information is not what they are expecting according to their objectives but after we report they see the importance of also including that meaning that next time when they give us that funding they also amend their objective, they also revise their objective to say okay now let's also include one, two, three* (Ellen, interview)

To further substantiate the above, here is an excerpt from the interview I had with the TVEP finance manager:

> **Q**: *As a follow up to the previous question, do you always follow everything you would have stated in the call for proposals when you are now implementing the projects?*

**A**: *I am not sure if I get you well but from understanding of your question I can say that these things are very tricky. You know what? It is us who are on the ground and the funders are not always here to see what we face. But from small understanding because you know I don't go into the field but from what I know we always see that new things come up when the project is being implemented. We cannot as an organisation just ignore. We can see that we include other things if it is necessary because things do not always turn up as expected. But these adjustments do not really go off very far from what we have agreed with the funder. So I can say we add some things as we go* (Interview, TVEP finance manager)

This shows that as individual actors of the grassroots organisations in question go about with their work in the field, they discover new areas of concern that do not only drive funders to adjust their originally stated objectives, but for the grassroots organisations to roam in uncharted territories. Two questions arise that seemingly casts shadows on the hegemonic character of institutions or structures. First, does not the fact that grassroots organizational actors discover new things that open grounds for negotiation with funders points to actors' control of circumstances? Negotiations are crucial elements of compromises, and where there are compromises the immutable nature of structure is interrogated. Compromise is certainly a potential avenue to change – and Sewell (1992) reminds us that once change is mentioned in the discourse of structure, there is an awkward epistemological shift. Structure, with its assumed imperviousness, rigidity and primary properties seemingly doesn't accommodate discussions on change (compromise is embodied in change). The second question that arises is closely related to the foregoing; if funders are inclined to alter or adjust their objectives, is it not also a digression from their own cultural schemas embodied in their original objectives that are now to be sacrificed on the altar of change and adjustment? An affirmative response seems inevitable here, and should that be the case, the argument which has been built thus far in this section – the argument for institutionally or structurally moderated conduct – will lose all verve. Fortunately, change is not the absolute opposite of structuralism.

Pierre Bourdieu posits that mutual reproduction of schemas and resources (human emotion and knowledge) constitutes abiding structures. This means that human emotion and

knowledge seemingly denotes agency and potential for change but these key components of an individual are in keeping with and serve to reproduce structure. In 'Outline of a Theory of Practice', Bourdieu (1977)'maintain that schemas and resources so powerfully reproduce one another that even the most cunning or improvisional actions undertaken by agents necessarily reproduce the structure' (Sewell, 1992. p 15). Sewell agrees and adds that change should not be seen as external to structures (Sewell, 1992). He argues that structures (schemas and resources) are not 'strictly homologous' even in the same system or institutional setting (Sewell, 1992. P 16). It is this heterogeneous nature of components of a social system that creates possibilities of change from within that system. Thus when grassroots organisations engage in compromises with the funder this does not in any way points to externally generated change or a compromise driven by a foreign actor. Even if compromises or change are to be seen as externally generated, the components of the externally generated change should at least possess some semblance of the already existing schemas and resources in the setting that is about to embrace the change and compromise. More so, even if the semblance is faint, pre-existing schemas and resources serve as a reference point or the axis upon which the understanding of external ideals are understood and accepted. So, even externally generated change finds its meaning in pre-existing schemas within the setting where change is to occur. In the case of the adjustments made by the organisations and funders in the field, TVEP and its stakeholders embrace adjustments that do not stray further afield from their structural orientations. Nomatter how varied agency is; it is dependent on the structures that inform the social world that the agent finds himself in (Sewell, 1992). It is a schema and resource (structurally) oriented agency. It is like the agency of a Christian, who, 'without the notion of heaven and hell … cannot strive for admission into paradise' (ibid. p 21). This Christian strives as an individual and making improvisional actions to eschew sin and excesses, but all done within the notion of pre-set schema on heaven and hell. So while the agency of TVEP actors and funders is evidenced in compromises and adjustments, it is bound by schemas that define their respective social worlds. It is an institutionally moderated agency which is not sufficient enough to warrant these adjustments as revolutionary. All parties involved preserve their identities notwithstanding or in spite of compromises.

Furthermore, it emerged that sometimes the organisations take funds for projects that do not exactly fall within the confines of their stated interests and goals. Not only so; should funders maintain a rigidity and chose to stick to the script of their own goals, the community organisations engage in subtle innovative strategies. They will take the funding; word some

of their objectives to suit the funder's requirement on the call for proposals, whilst being cognizant to the fact that they will sneak in some of their objectives which were not the direct funders' focus. This creates a platform for negotiations with funders once the project is underway. The organisations realized that they will have more leverage when they negotiate with the funder after they have gotten hold of the funds. It is unlikely that the funder will withdraw resources once a project has been set in motion. Masikwa had this to say,

> *Sometimes because of challenges we do try to take risk for example we apply for funds that are not really addressing our challenges …for example you see that out of five the funder wants to have two issues that are part of our thematic areas the other areas are not. So we do these things carefully. It is a bargain and you also have to maximise out of it. At the end of the day isn't it that the beneficiaries get what they are supposed to get. So it is not only about what the funders want done…we also see the need to do things which are close to what was advertised even* (if) *these things were not directly in the calls for proposals. Isn't it that we are the ones who implement these projects? I think we have a better understanding because it is us who will go into these communities practically* (interview, Masikwa)

The same was reiterated by the Monitoring and Evaluation officer of TVEP, Tapiwa, who explained that whilst he feels funders have got more say, their organisation has a way of engaging with the funder to incorporate objectives which might have not been originally on the funder's list. This was not only confined to TVEP; Pastor Maphosa of VPBP, when asked if there were instances they managed to incorporate objectives not originally called for by the funder, gave this example,

> *Yes yes yes. We remember ...the funder was looking at xenophobic attacks of foreign nationals but we ended up realizing that that is not the only need …the communities they need other services which they were promised by the government. ..we ended up informing the funder that we are not only looking*

> *at the xenophobia...and the funder would say just try to merge it together and then we will support you and it did that very well* (Interview, Pastor Maphosa)

Once projects are underway, that is when they are being implemented; sneaking in of other objectives is done casually such that the funder will not see it is as confrontation to their original objectives. That way, grassroots organisations will make all of their objectives gain traction, objectives which would not have gotten funding had they been presented in formal ways. Organizational interests are thus served through subtlety and innovation. This shows a measure of innovativeness. This in a way confounds Weberian bureaucracy (though community organisations are not bureaucracies) which sees institutions as overlords over individual actors. The regulatory pillar, one of the ways by which Scott (2014) explains institutionalised conduct is also pushed further since empirical evidence points to knowledgeable actors who are innovating and cunning. However, as innovative as these actors are, we risk adopting material determinism in which the idea of agency is overly romanticized such that actors seem independent of cultural schemas or social systems. Such material determinism is one of the grounds for Sewell's critique of Anthony Giddens. In pursuit of duality of structure, Giddens (1976) emphasizes actor's knowledge and ability such that even if there are rules; it takes knowledgeability and emotional commitment to follow them. Sewell thus criticizes Giddens for not developing a vocabulary which specifies the content of what people know i.e. the source of this knowledgeability (Sewell, 1992). Sewell thus develops this vocabulary; what people know is culture (ibid). Thus, while we celebrate agency or innovation reflected in clever sneaking in of objectives into the funder's purse by organizational actors, one should not be over excited and forget that such innovation or knowledgeability is a reflection of the cultural schemas of the broader society or social systems that actors find themselves in. The sneaking in of objectives or thematic areas is ultimately in keeping with these organization's broader goals in providing services to the subalterns who include migrant populations. Sewell (1992) puts it in an interesting way by giving an analogy of language; that linguistic capacity is nothing but within the bounds of becoming a competent speaker of a certain language – an already existing language. Therefore 'agency is formed by a specific range of cultural schemas and resources available in a person's particular social milieu' (ibid. p 21).

In opening this segment, a biblical allusion was made to the effect that freedom from the dictates of the law of sin, a structural constraint, was made possible by paying allegiance to the dictates of the law of righteousness, another structural constraint. This portrays a picture where freedom from certain constraining institutions can only be explained by constraining institutions elsewhere. In the spirit of this allusion, and as demonstrated in this segment, community organisations' ability to negotiate the funding terrain and avoiding the lordship of funders can be explained by their dedication and allegiance to organisational goals which are reflection of schemas of institutions in their social system. This culminates to the fact that community organisations ultimately pursue their goals in whichever projects they implement. It is clear that the preservation of organizational identity is paramount even in the face of those with material resources. All seemingly individual innovativeness is culturally and historically determined. The use of human resources (emotional commitment and knowledge) is very individual but only to the extent they instantiate and embody cultural schemas. Adjustments and compromises by organisations are by their very nature changes, and change is an antonym of stasis in abstract terms. But in contextual (the context here is the empirics) terms, adjustments and compromises by the organisations is an inculcation and justification of schemas i.e. organizational values and norms. Therefore, whatever the grassroots organisations pursue it is in keeping with organizational goals. Organizational goals influence organisations to provide services to target populations and how these services are provided.

## 5.4 'We challenge them according to their own stipulations': The working relationship of the government and community organisations.

In this section, by analysing the working relationship between grassroots organisations and the government, I forward the argument that grassroots organizations' conduct is mainly in keeping with their goals as an organisation. These organisations pursue projects and ideas that are consistent with the values and norms (schemas) of the broader societal structure within which they operate. This section will harness excepts of Giddens Duality of Structure proving that structure serves both as a medium and outcome of all actors' practices that make up social systems (Giddens, 1981). Evidence shows that grassroots organisations challenge government policies and hold the government to account. The interviews increasingly showed that while the organisations were working with the government, sentiments of resentment and mistrust towards the government remains a defining feature in the relationship between NGOs and the government (Bratton, 1989; Batley, 2010). While this troubled relationship did not explicitly show how it negatively affects distribution of services to subalterns including migrants, it is clear that it influenced and accounts for interventions that are in response to observed need not to a solid programmatic intervention.

Grassroots organisations were very clear that they challenge the government should they feel that the latter's approach does not fall within their cultural schemas. Community organisations understand themselves to be the ones who understand the interests of the societies they work in. They have a shared meaning of phenomena due to the fact that the organizational actors come from the community hence shared experiences and conceptions of phenomena. When the government introduces new policies, it is upon the community organisations to conscientise the community on the policy meaning and implications. Masikwa from TVEP said:

> *…when the government is passing a policy or law we go to the extent of interviewing communities because those laws will be on white papers for people to comment but often you see communities don't have resources…but with us we make sure we organize them* (interview, Masikwa)

If the proposed policy contradicts the values and norms of the society or cultural schemas (which are one way or the other reflected in organizational goals), the proposed policy may never find its way through to the intended targets. The policy might be dropped or adjusted by the government to suit the social experiences of the intended targets. Masikwa gave reference to a bill which had to be shelved since it contradicted TVEP's conception of what is appropriate. In reference to that he said:

> *...we realise as an institution that we still have patriarchal chiefs and once they can get the same powers as the magistrate they will use them against our vulnerable groups so we needed to get a balance in terms of challenging some aspects of the Traditional Courts Bill...so that bill was set aside because we were very proactive in challenging it* (Interview, Masikwa)

From the above, community organisations challenge the government and its proposed policy which they feel contradicts with the ideals or schemas of their society. This is one of the explanations of the troubled relationship between the state and non-state actors. Bratton (1989) and Batley (2010) explain how it is difficult for the state and NGOs to collaborate and coexist peacefully since the latter has developed a practice of policing and challenging the government. This explains why NGOs in Zimbabwe have been suspended countless times under the presidency of Mr Mugabe; the regime saw NGOs as provocateurs and agents of foreign interests who defeat and confront what the government stands for (Batley, 2010). While the Zimbabwean situation might be too strong an example since the sour relations between the NGO and the state were premised on politics; this study demonstrates that NGOs approach their partnership with the state from the position of policing the state and holding it to account. This is worrying especially when one considers, as stated by Acharya and colleagues, that the state should exercise a coordinating role on those who have interests in service delivery (Archarya et al, 2017). How will the state play this role if one of the key partners approaches its relationship with the state from the position of scrutiny and mistrust?

By 'proactive', agency is implied. Organizational actors are seen as having resources to challenge contradictory schemas from the government. These resources are knowledge and emotional commitment, according to Sewell (1992). And knowledge, or what they know, is

culture (ibid). Therefore we have resources and schemas reproducing each other thereby maintaining the structural integrity of the organizational sphere. People have knowledge, and their knowledge is a sedimentation, reflection or instantiation of cultural schemas. In that case Pierre Bourdieu's 'habitus' finds credence; the notion that schemas and resources reproduce one another that even the improvisional actions of actors serves to reproduce the structure (Bourdieu, 1977). The proactiveness of organizational actors is therefore framed within the reproduction of what they have come to believe to be ideal in their organizational sphere. It is framed within cultural schemas.

However, this tends to erect 'combined determinism' (Sewell, 1992) which Sewell reminds us not to for duality of structure or institutions is supposed to mend such deterministic understanding of structures. To say that schemas and resources reproduce one another such that even individual cunningness serves to reinforce existing schemas, as said by Bourdieu, creates a hopeless picture where change and compromises are foreign to institutions. In the interview above, such a picture is confounded because, though we have previously determined that community organisations and the community are one (they share schema and resources), we see that within that same community exist chiefs who are patriarchal; and organizational actors are anti-patriarchy. How then can we say organizational actors' proactviness is in keeping with the community's schemas when they seek to challenge a practice that constitutes their culture? Patriarchy is part of a schema or cultural practice in this community yet we see members of that same community resisting a Bill that seeks to reinforce these cultural practice? Dissent is emerging within a system that is supposed to be self-preserving and self-producing. When change and dissent occurs in Hawaii, Sahlins (1981) argues that it is externally generated because he cannot fathom a supposedly self-preserving system adjusting itself. How then do we explain this seemingly paradoxical occurrence where dissent arises in a system which is overly presented as agent-proof and self-reproducing?

It is productive to follow Sewell's guide. Sewell accepts and upholds duality of structure. His paper 'A theory of Structure: Duality, Agency and Transformation' (1992) is dedicated to duality of structure. However, his is a sober view which, while maintaining the notion of schemas and resources reproducing one another, seeks to explain the possibility of change and dissent within this seemingly self-reproducing system. Citing Rosaldo (1980) and Sahlins (1981 and 1985), he argues that those 'same reproductive biases of structure that explain the powerful continuities of social relations also make it possible to explain the paths followed in…social change.' (Sewell, 1992. p 16). A full exegesis of his intellectual contributions is

beyond the scope of this work, but suffice to say is that he locates change within the self-preserving system. He asserts what he terms ‘multiplicity of structures’ and ‘transposability of schemas’. The former explains that structures are not homologous but vary with institutional spheres within the same society while the latter explains how schemas are transposable or can be extended to contexts unfamiliar to the ones they were adopted albeit in the same social system. This can be useful in explaining why community organisations, while hailing from the society, can challenge certain aspects within that society while continuing to exist as one with the same community. Anti-patriarchy is a schema adopted from a different institutional sphere (perhaps educational) and it has been transposed by organizational actors into the governance sphere (the seat of the patriarchal chiefs) of their community. Though the community or society might be one, actors exercise agency by expressing their ability to transpose and extend a certain schema into an unfamiliar territory (ibid). The organizations’ stalling of a Bill that supposedly is in sync with one institutional sphere of their society is a demonstration that actors have agency. However this agency still remains culturally determined because the transposed schema was fetched from the same system albeit form a different sphere or institutional setting (there are multiple schemas and resources within one system). Thus the system is self-maintaining and self-adjusting simultaneously. Individual behavior and resistance of a bill remains institutionalised and therefore what drives the organisations to do what they do in the community is structured.

Also, from the same interview we understand oneness between community organisations and the community. Vulnerable groups of the society (women and children in this case) are seen as ‘our’ by TVEP. The organisation assumes possession, or acknowledges an already existing guardianship of the vulnerable sections of the community. By ‘our’, TVEP acknowledges sameness between them and these vulnerable groups. They share identity and are thus one. Some of these vulnerables are their very aunts, nieces, uncles, neighbours and church mates (as was seen during my stay in the field where organizational actors and community members interacted in less formal means). They share physical and social space, and meanings to phenomena. Thus when it comes to statutes that affect them, empathy and affect are evoked. ‘Our’ defeats professionalism and aloofness or detachment – it rather shows organizational actors straddling the territory of emotion. Creed, Dejordy and Lock (2010) says that when symbolic systems (the Bill in this instance) are in disagreement with individual demands, emotions drive actors to alter or dismiss these systems.

But how do organizational actors whom we have established to be transposing an anti-patriarchy schema into an unfamiliar territory (not in a geo-physical but spatial – a different institutional sphere within the same structure) managed to appeal to the knowledge and emotion of the community? It is critical to state that if schemas are not static –they are transposable – their effect on resources (emotions and knowledge) can never be static or predictable too. This is Sewell's idea in his endeavour to explain change from within an 'intact' system (1992). Resources (human knowledge and emotional commitment) within the unfamiliar sphere to which schemas (in this case anti-patriarchalism) have been extended or transposed can either accept or reject the new schema (new not as in external to the system, but new as in originating from a different institutional sphere within the same system). Acceptance of a new schema unseats previous schemas. Empirically, community organisations managed to transpose an anti-patriarchy schema into a new institutional sphere and it was accepted. TVEP, its compatriots and the community are in a one structural system though they sit in different institutional spheres. The actors of the former transpose and extend schemas generated in their sphere into another sphere within their community. These schemas appeal to the resources in this other sphere and therefore TVEP schemas and resources identify with that of the broader community. That way they stand as a unified system or structure in rejecting the Bill proposed by the government. However, the resources (emotions and knowledge) of individuals in the community to which a new schema has been extended are properties of these individuals only to the extent that they exist in relation to other minds with shared meanings – the other minds being community organizations' actors. (Mead, 1982). Simply put, the rejection of the Bill was an institutionalised or structured action.

While community organisations seem to be the proverbial thorn in the government's flesh, they nevertheless have to work with the government. However, community organisations, building on their understanding that they are 'foot soldiers' who have an unlimited access to the community, feel that they have a huge task of adding value and flesh to government interventions. Interviewees prided themselves in their ability to broaden the scope of state interventions. Speaking on interventions they do in schools around the Kutama-Sithumule area, Ellen said,

> *... for example when it comes to the policy the government will distribute the policies to the schools for example so tina (us) when we go there with our projects we find that there are some information that are missing in the policy that can help the students so what we do we sit down first with the principal and the school and then we present our project to the school then after that we give them opportunity to check their policies to see if they align with what we will be doing in the school. If we are dealing with HIV you find that when it comes to, I am just giving an example, when it comes to PEP (Post-Exposure Prophylaxis) for example it's something that is very new, neh (right?), let's say it's not included on their policy gore (that) when someone is rapped there is need to follow certain procedures that ensure PEP is administered…it's something as TVEP when we are doing our presentation we need to present and give them all the details that talks about the project then after that they will see the importance of adding the information on their policy so that next year even when TVEP is no longer there they will be able to tell the students about what is happening…*(Interview, Ellen)

This is an example of grassroots organisations influencing how certain government interventions can be properly implemented. Key to note here is that 'properly' is defined by the organisation based on their own experience on the ground. What this shows is that mistrust and confrontation is not the only defining feature of NGO-state relationship. As stated in literature, public-private partnerships are useful in ensuring that one partner compliments the strengths and compensate for the weaknesses of the other (Acharya et al, 2017; Loevinsohn & Harding, 2005). However, as the evidence in the preceding sections show, it is this knowledge that they complement and compensate for the weaknesses of the government that places NGOs on a pedestal of pride which makes them see the inadequacies of the government hence the need to challenge it.

As pertaining to what influences grassroots organisations to implement certain projects, surely the government as an actor is not one of them. The government proved to be one of many accessories that NGOs use to pursue its goals. These empirics feeds into the intellectual explanation that schemas of a cultural system in which the organisations are based is a driving force behind the work that they do. So, what influences grassroots

organisations are schemas and resources that are within their social systems – it is their values, norms, emotions and knowledge that are instantiated and sedimented in their thematic areas. It is against these schemas or systems that government interventions (other schemas) are measured. As long as government interventions have a semblance of what community organisations are pursuing, the two can work together. I have previously established, guided by Sewell, how there are multiple structures in a system and how schemas within different spheres in a system can be transposed or extended to different circumstances (Sewell, 1992). The interface between government and civic society in the example above proves within and beyond Sewell that schemas can be transposed beyond one system (the community and its organisations) as we see two different systems (government and philanthropic organisations) work together notwithstanding some fundamental differences in the schemas and resources that underlies their existence.

In cases where community organisations are not at odds with government policies or interventions, they drive the government to implement. The common theme that came out in interviews is the ability of grassroots organisations to hold the government to account. This shows that while community organisations and the government may work together, the former does not see itself as obligated to the government; it is rather the government that is obligated to the grassroots organisations. John of TsVEP stated that:

> *We challenge them according to their own stipulations, mandates, and policies. We hold the government to account. Our job is not like we are fighting with the government. We are just saying look you said this and this so do it. We are just asking them to do what they have promised on their own. So we are here to make sure that the government is doing what it promised that it will do* (Interview, John)

To add on to this, Pastor Maphosa explained:

> *…people used to stay for more than 2 weeks without water…and we had to go engage the local leaders…chiefs, SANCO…we realized that it ended there*

> *until we even have to engage the minister…and people managed to get water…*(Interview, Pastor Maphosa)

Here we see grassroots organisations acting as the advocates of the people which further adds into their claims that they are effective than the government. Not only do community organisations affect the content of policy, they also police the implementation of policies they feel are in agreement with their organizational goals and purposes. Such relationship between civil society and the state is not new. In the early 2000s the civic society was instrumental in seeing that the government give Anti Retro-viral Treatment (ART) to HIV patients (Wouters et al 2007; Wouters et al 2010; Ngwena and Van Rensburg 2002). The civic society, whilst located in the sphere relegated to the duty of policy implementation, proves very well that it is not a passive barrel through which intends and purposes of the state or policy makers flow to the intended recipients. Of course, when the state makes policies they do not specifically make them to be implemented by non-state actors. The state expects its arms to bear this responsibility. However, the supposedly implementation sphere (where government facilities are located) has actors apart from the state who are instrumental in how policies are implemented and challenging the content of these policies. Perhaps it is time that we increasingly adopt a paradigmatic shift in the understanding of the grass roots as a mere implementation sphere.

In the interviews, it became clear that grassroots organisations in many instances were seen as an enemy by the state especially when the latter feels that its authority is being challenged. Masikwa said:

> *Our advocacy work always put us on the other side like in terms of getting funding (from the government). Sometimes even when there are government imbizos, national meetings…they will not even invite us intentionally because they know we will challenge things…they will only invite those who say yes baas yes baas yes baas* (Interview, Masikwa)

The TVEP legal officer also explained how their approach to various issues affects their relationship with the government:

> *Honestly speaking it is not good it is a hick up you know it is a challenge. But we are not fighting with them but we are bringing them to the drawing board on the things that they have committed themselves. You see you have written a book and say a procedure…to say we will do these on the victims so we are not fighting we are saying okay guys let's see the procedure now, you have said this*

Other directors echoed the same sentiments stating that the government does not want to be challenged and it prefers to work with those organisations that have an aptitude to comply with whatever the government says. As literature says (Bratton, 1989; Batley, 2010), this is what defines the relationship between the government and civil society organisations. What emerged from the aove evidence is exactly what Acharya and colleagues have observed. They state that the reason why the state does not want to engage NGOs is that their operations qualify more as competition than collaboration (Acharya et al, 2017). In this study, the NGOs were working with the state but it is evident that they have no high regards for the state and this influences their approach and behaviour when working with the state.

However, grassroots civil society organisations are not bent on challenging the state for the sake of it or as mere show of wits. Previously I pointed out that actors in these organisations are one with the community since they have a shared identity that comes from shared meanings of phenomena; that organizational thematic areas are social facts that reflect ideals of the community within which these organisations are stationed. During interviews, it became clear that the actors in the organisations I was working with feel an attachment to the community than they feel obligated to adhere to policies which in some instances they see as bureaucratic hurdles that hamper their efforts in dispensing help to the community. When asked about if there are moments when the work of his organisation sometimes goes against stated government procedures or policies, John gave two examples:

> *Yes. Most of the time. I kept a six months old for a weekend she was thrown away by the mother. The mother was nowhere to be found. And we can't just throw the baby anywhere. I have to keep the baby at my house for the whole weekend and then I take the baby on Monday to the social workers. The government policies do not allow what I did. A few months ago we kept a five year-old baby in our organisation (with a raised voice) but the policy of the government does not allow us to do that. But can you leave the baby sleeping on the donga (abandoned house) or under a tree? Circumstances force you to do that.*

He went on to say

> *In 2016 we have a problem of another family they are mentally retaliated (retarded) but they just keep on giving birth baby after baby but when you ask who is the father but those girls they don't know the father. We had to force them to sign the consent form for them so that they can terminate the pregnancy…but we tried to consult the social workers but they say hey the policy doesn't allow us but…we have to force to do it. Sometimes some policies are not favouring towards civil society but when things are right I have to* (do them despite policy stipulations) (Interview, John)

It is therefore not mere acts of testing the government or a show of blatant insubordination. John says circumstances forces him to do so. What are circumstances? Here it is clear that John as an individual actor (though representing his organisation) is not impervious to adjustments. It should also be made clear at this point that what John and his organisation did is also contrary to their own stated code of conduct which must be aligned with government regulations. But what is the source of such malleability on his part? Systems are not rigid though they have power to regulate human conduct. John's organisation was confronted with situations that required transposing the schemas from one sphere into another. It has been

previously explained that within a single system there are multiple structures and schemas that can be extended from one structure to the other (Sewell, 1992). TsVEP as an organisation is an institutional sphere or structure with its own logics that are different from the logics of family or kinship structures. The logics of the kinship structure have schemas of empathy and compassion whilst TsVEP logics are quoted with professionalism. John and other actors therefore transposed or apply schemas of the kinship structure to another sphere i.e. their organisation. This explains their conduct in offering assistance in forbidden ways. Such adjustments are not an affront to the ethos of their institution because, according to Sewell, they are simply extending a logic from one structure to another, and these structures are different aspects of a single system i.e. the community they are domiciled in. Thus, while an adjustment or compromise may imply a tempering with structure, it is ultimately in keeping with the broad communal system. Their actions exhibit agency while simultaneously reinforcing structure.

In conclusion, evidence shows that grassroots NGOs, just like any other NGOs as stated in literature, are very close to the communities they work in and this creates a sense of ownership of the community. They believe they are custodians of the community and this explains the source of their view that they are more effective than any other actors in providing services to the community. Yet these poses the danger of them being gatekeepers in multiple ways. Not only is this source of pride, it is also the source of their contempt for the state. The state knows that and the relationship between the two is unsurprisingly not very good. Intellectually, the behaviour of NGOs can be understood from social systems and structure. People in charge of the NGOs demonstrated agency in their ability to adopt cultural schemas from other social systems and transpose them into their organisational settings. While this is agency, but it was clear that this agency was exercised in selecting already existing elements within a social system which means that that their agency is within the boundaries of structure. Therefore dynamics of what grassroots organisations do are embedded in structure, hence the conclusion that organisations are influenced by institutions or structures in their interventions.

# 6 Chapter 6

## 6.1 Factors influencing the provision of public healthcare services by public healthcare professionals to migrants.

### 6.1.1 Introduction

This section reports on and discusses the themes that emerged in the study as the researcher interviewed and had conversations with public healthcare professionals in three clinics and one hospital. Harnessing street level bureaucracy and institutional theory, the researcher observed that health care professionals' decisions and conduct within the work space as they interact with the migrant patient is largely influenced by institutional or structural factors beyond the bureaucratic sphere. Street level bureaucrats subscribe to various institutional spheres that have their cultural schemas, resources and ideals which regulate the bureaucrats' behaviour even in the wake of other factors within the bureaucratic sphere that might potentially shape their behaviour. Religion proved to be of strong influence as the healthcare professionals embraced the ideals and schemas of these institutions and transposed them to their workplace to make meaning of various circumstances within that environment. The chapter reports how the cultural orientations of the bureaucrats serve as the practical policy regarding whether and how services are provided to migrants, a point which has much in common with how NGOs in this study operated. There are no specific regulations that speak to migration and the few national policies that exist are not known to the service providers. Ultimately, the chapter shows the usefulness of opening up street level bureaucracy theory to the tenets of the institutional theory in understanding the behaviour of government facility workers since some of the behaviour exhibited within a bureaucracy emanate from other contexts apart from the bureaucracy

## 6.2 Factors external to the bureaucratic sphere influence the conduct of street level bureaucrats

Using empirical evidence, I argue for the need to reorient Street Level Bureaucracy (Lipsky 1980 & 2010) for one to fully understand and explain the behaviour of street level bureaucrats in bureaucratic settings. I propose that scholars transpose Sewell's (1992) ideas on structure, duality, agency and change into Lipsky so that allowance is given for other institutional determinants (schemas and resources) other than those in the bureaucratic environment. To prove this need the section will use interviews conducted with health care professionals and Sewell's ideas to explain that street level bureaucrats are not only affected by circumstances in the bureaucracy; that they have allegiances to other institutional spheres which have their own schemas and resources that shape behaviour; and that these schemas and resources from other institutional spheres can be extended and applied to other institutional spheres (in this case the bureaucracy). While explaining this, it will become evident that ingenuity and innovativeness of street level bureaucrats can produce positive outcomes for the bureaucracy especially when the schemas and resources moderating the bureaucrats' behaviour are from the religious institutional sphere. Ultimately, the discussion will show that multiplicity of structures and institutional spheres; and transposability of cultural schemas from one sphere to the other (Sewell, 1992) are key ingredients in the reorientation of Lipsky's Street Level Bureaucracy.

### 6.2.1 Street level bureaucrats' discretion and district expectations

In interviews with Operational managers, it was explained that clinics fall directly under the district and are not affiliated to any hospital which is under jurisdiction of another sphere of government, i.e. Province.\. In an interview with the operational manager of one of the clinics, the nurse explained that it is the district that manages their facilities; provide drugs; maintenance and approves who they should work with especially when it comes to the civic society. Here is our discussion:

***Q***: *Is this a district or provincial facility?*

***A**: It's a district facility*

*All the clinics fall under the district we are not actually affiliated with any hospital. Whatever we want we get it from the district.*

***Q**: How does the district contribute to the functioning of the facility?*

***A**: Maintenance and everything*

***Q**: Who approves your working with TVEP?*

***A**: The district, they give them a letter. If someone is from the district we have no objection*

***Q:** Are there programmes you implement without the direct involvement of the district?*

***A**: Yes, because the district they usually supply us with material and things to work with but we are the ones who see to it that something I have been given by the district I place it here even if the district says it should be placed here I use my discretion. As a facility manager I should use my discretion even when the district says it should be put here but when I use my discretion I see it is suitable to be placed here*

***Q:** Any examples?*

***A**: We can have our nurse campaigns without informing the district, awareness campaigns involving the community*

***Q:** Is there anything u can point here and say this is my initiative or its all within the boundaries of work and rules and guidelines?*

***A***: *No you don't do your own thing…my job is to improve what is given like the district says it should be used this way but I feel it's better this way*

The above shows that the district has control of some sort on local facilities. However, this control only goes as far as overseeing; the nuances of the clinics operations rest on the operational managers' discretion. The same point was raised by one of the operational managers of one of the clinics:

> *My son, the district is the one which acts like a chief on this facility. Most of the things we do here must get approval from the district. You have come with the TVEP people and it is the district that gave us the go ahead to work with them because the TVEP people came with an approval letter from the district offices in Thohoyandou. But to be honest with you I am the manager of this place and I have to use my own brain on many things. Sometimes the resources we get from the district are not enough and it is me who has to decide which material go where. Sometimes I do what I think is the right thing to do because district people are not on the ground. I am the one here so I know exactly our problems so I decide what is good for solving the problems we see here.*
>
> *You cannot always do things according to the rules my son. Sometimes you can see that this thing work even if it is against the rules. I remember one thing. You know…HIV treatment for people who have TB requires that the TB must be treated first before we administer the ARVs. One woman* (came) *here with HIV and TB and according to rules we were supposed to first refer her to Louis Trichardt for the TB before we treat her HIV. But this woman did not want to go to Louis Trichardt because she was afraid she might be admitted and her family back here will have no one to look for* (after) *them. But we looked at her and she looked very well so we did not see any problem and we break the rule and give her HIV treatment. It worked* (she laughs*). So my son books are good but you also have to use your brain.* (Interview, Operational manager)

Under audio tape recording one of the facility managers stated this

> *We are directly under the power of the district. I must not do my own things here. There can be litigations if it is found that I am doing things my own way. I stand for the district so I do everything according to the rules and guidelines*

But she stopped midway and wanted to know if the recording will be safe. I assured her that the recording will be safe and it will not be accessed by her superiors. After I gave this assurance, she stated things which were somewhat contrary to what she had initially said. She said that it is not always that you have to follow the books:

> *We are on the ground and we really know and see the problems here. For example you will find that we have some nurses here who have let's say speciality in maternity I have to sometimes allocate the duties according to the demands of the day. You see that today we have got many patients who need help here and the front desk is very busy so I had to ask one nurse to assist there. You also see that there are many women who are pregnant and they need urgent attention. I have to ask some helpers they are not qualified nurses but they now know some of the things so I have to ask them to do the work. We cannot suffer alone because the work sometimes is very huge and the district people are not here to see that. The district expect us not to use helpers to do these kind of things but we have to because if we don't things will not move. We do what we have to do here*. (Interview, Operational manager)

From these interview extracts it is clear that the issue of resources has part in influencing the decisions taken by the facility managers. Lipsky states that inadequate resources is one of the factors that account for the discretion of the street level bureaucrats as they go about with their daily duties (Lipsky 1980 & 2010). He states that inadequate resources constitutes lack

of resources and understaffing and that street level workers may become overwhelmed by tasks assigned to them and may sometimes be inexperienced to perform certain tasks assigned to them which culminates to a stressful environment which makes it unrealistic for them to stick to abstract directives on paper. In two of the three facilities, understaffing was a significant factor; lack of qualified personnel meant that the managers had to veer off the stated procedures. Even apart from lack of resources, street level bureaucrats' work, as observed by Kelly (1994), is inherently discretionary. Street level bureaucrats are inventive and possess the capacity to navigate and negotiate the work setting (Moore, 1987). Thus, while the district have influence on the facilities, the fact that the healthcare professionals are on the ground every day and are in contact with patients and circumstances that mean very little when directives or books (as the nurses would call them) means that the nurses have to be inventive and do things they see fit at any given time.

Thus street level bureaucracy is very useful in understanding how local level facilities function. As proven by evidence in the above interview extracts, the circumstances within which the bureaucrats exercise their duties influences their conduct. However, it is not always that the work environment influences bureaucrats' conduct. The work environment is only one of the factors that moderate the behaviour of street level bureaucrats. This thesis is of the view that Lipsky paid too much attention to the work environment in explaining the discretion of the street level bureaucrats. Some might argue that his theory has got other tenets apart from the work environment. It is true. Some of these tenets apart from inadequate resources are an ever-growing demand for their services, vague and conflicting goals, and provision of services to captive clients (Erasmus, 2017). Yet a closer look at these tenets will still leads us back to the work environment. All these factors are encountered by street level bureaucrats at the point of contact with the clientele; and this point of contact constitutes as the work environment. But as evidence will show in the next section, the behaviour of street level bureaucrats cannot only be accounted for by the work environment. If we are to qualify the work environment as a structure that models behaviour, then it will follow that only one structure is a determinant of the street level bureaucrats' conduct. This is however not the case. To prove this point I use evidence from the interviews and make use of William Sewell ideas on structure, duality, agency and transformation (Sewell, 1992). Explaining the empirical evidence using Sewell's insights will show that there are various structures in the social systems of the street level bureaucrats whose schemas influence how the bureaucrats

interpret the circumstances when they are in contact with patients, particularly the migrant patient.

### 6.2.2 The transposition of schemas from elsewhere into the work setting

As stated above, this sub section builds the argument that whilst being effervescent concerning Lipsky's contributions in understanding the behaviour of frontline workers is justifiable, there is need to move a step further and acknowledge that the behaviour of street level bureaucrats can also be explained from outside the circumstances of the work place. The work place is only one of, not the all-encompassing, factors. Sewell posits that within a single social system there are various institutions or structures which have schemas/ideals which can appeal and shape the resources (knowledge and emotional commitment) of the actors who are in contact with these structures (1992). I use this insight to explain how religion, as discovered in the field, has schemas and ideals that appeal to the resources of the street level bureaucrats which ultimately moderate and influence how these frontline workers interact with the migrant patient. Going into the field the researcher had hypothesised that the views that health care professionals have on migrants and migration in South Africa will inevitably influence how they provide healthcare services to them. This was however confounded by what I discovered in the field. Religion proved to be instrumental in influencing how street level bureaucrats interpret directives from the district and how they also interact with the migrant patient. But what is important to note is that there are no specific programmes that acknowledge migration.

The interviewees were very clear that they can only follow rules and regulations up to the point they are still in agreement with their religious orientations. I had a lengthy interview with one of the operations manager of one of the clinics in which in the beginning she was stating that what she does is in keeping with the nursing guidelines on how she should conduct herself in her profession. She sounded very professional saying

*You don't do your own thing…*

But when juxtaposed with responses she gave later, it is clear that the rules and regulations or the codes of the nursing profession are binding but only to the extent they are still congruent to other influences, particularly religion, that seems to guide her daily life apart from the nursing sphere. This is so because she went on to say,

> *We are in democratic world. I don't think a person from the district can force you to do things against my religion. Everybody has freedom of choice* (Interview, Operational Manager)

To consolidate the above, she gave the following example;

> *I personally was told to do a TOP (termination of pregnancy) so because that is against the rules of the bible I just said I cannot do that it's against my religion and no one ever fought me on that* (Interview, Operational Manager)

This is a demonstration that she pays allegiance to a higher celestial force which in her own words cannot be compromised. If there is anything that can be compromised it is the rules that are in the mundane world i.e. professional conduct. She was adamant and showed a great deal of emotion when she said the following.

> *I follow some rules and regulations but when I come to a certain place where rules and regulations conflict with my religion I put my religion first. I don't compromise my religion* (Interview, Operational Manager)

While she did not manage to give other examples where the code of conduct is subjugated to her religious inclination, this is a clear validation of Lipsky's (1980) conception of

bureaucratic behaviour by the street level bureaucrats. Lipsky's 'Street Level Bureaucracy' is a decrying of the works of Weber and Taylor who portray street level bureaucrats (those who work in bureaucracies) as passive and mere subjects who invoke technical procedures which are prescribed from senior offices (Moore, 1987). In criticizing Weber's and Taylor's conventional organizational theories, Moore states that there is lack of clarity and some circumstances in the work setting that creates a gap between management and the street level bureaucrats. This is correct, but in the context where Moore gave these conclusions. However, in this context the interviewee was very cognizant of procedures and codes that standardize the nursing profession. The nurse in question could recite from her heart all the regulations; after all she is the facility manager who has underlings that she must constantly remind these rules. Moore and Lipsky, while correct in their quest to explain deviant conduct in bureaucrats, they over emphasise on factors within the work environment to explain such deviancy, defiance and stoicism.

The interview above however appeals to a need for the expansion of Lipsky's ideas. The services of Sewell (1992) are very useful in this task. To understand deviant behaviour or adjustments and compromises within one institutional sphere there might be a need to look at other institutional spheres whose cultural schemas may be imported into the sphere whose dynamics we seek to understand. In 'A Theory of Structure: Duality, Agency, and Transformation' Sewell introduces what he calls 'axioms' in understanding deviance and/or compromise (ibid). One of these axioms is 'transposability of schemas'. He posits that cultural schemas (ideals and norms) of another institutional sphere can be applied to another sphere and this can influence behaviour of the agents in the latter sphere that they may demonstrate behavioural traits that are not consistent with the schemas of this sphere. In this study, the facility manager takes the schemas of the religious sphere i.e. its logics and ideals, and extends them to her professional sphere to make decisions in certain circumstances. It might not be known whether the facility manager's deviancy may be to the good or bad of the clientele who seek services in this facility, but suffice to say is that street level bureaucrats deviate from stated rules as observed by Lipsky and others, yet such deviations cannot only be understood from the settings from which they immediately unfold. Such deviation is termed by Lipsky as innovativeness and strategy, and that is correct because to transpose and extend schemas is a manifestation of knowledgeability.

However, Lipsky doesn't go further to appreciate the structure character of such innovativeness. It is stratagem and innovativeness framed within structures from another

institutional sphere, in our case religion. Perhaps, and reasonably so, Lipsky was occupied with wanting to discredit that people are bound by structures of the bureaucratic sphere. In doing so he ends up erecting and upholding material determinism. Strategy and innovation are acts of agency but they serve to consolidate and instantiate cultural ideals of another structure.

Whilst the implications of the deviations of the above interviewee may not be known, the next one interviewee redeems this curiosity. Lipsky and literature that is congratulatory to his ideas speaks about the consequences of street level bureaucrats' innovation and deviation, and the consequences might be negative or positive for the client. However, the premises upon which discretion is exercised would mainly engender negative outcomes. For example, Kangelani Moyo reports how the working conditions in the facilities he investigated usually led to negative outcomes especially amongst migrant patients (Moyo, 2010). The health workers' conception and stereotypes of the migration in general and the migrant patient in particular meant that accessing or utilization of health services by migrants was an arduous task that required serious navigation on the part of the migrant. But this was not the case in one of the facilities I visited. I interviewed a nurse in Louis Trichardt Memorial Hospital in Makhado and what I discovered was not in sync with my expectations. Like the previous interviewee, this nurse also held religion with high regards and it influenced how she went about with her duties and offered services to migrants. When asked about how the conditions in her work station (they were not good, as shall be seen later) influenced her interaction with patients, especially the migrants, she had this to say;

> *...but because I am going to the church I don't say I am a Christian which* (who) *is not doing sin, but I say when I read the bible in 1Corrhintians 13vs9 it says love…then I say I am not loving the people because I am chasing them…then I just say to myself if someone comes after nine I am doing pap smear… now my heart is freely* (free) *I am going to church and singing freely because I am fighting with innocent people* (I used to)*because I was supposed to be fighting with the management not the patient* (Interview, Oncology nurse)

Off record, I had a lengthy conversation with her, and I took notes:

> *She said that she loves migrant patients because she is personally referred to as a migrant by her workmates since she is not Venda but Pedi* (Venda and Pedi are ethnic groups in different ut neighbouring parts of Limpopo). *She said migrants also love her because they know she is a Christian and they come to her without fear. She said migrants are God's people and they must be shown love* (field notes, 19/09/18).

All this behaviour is not because there were no working conditions that could influence her behaviour or make her vent her anger towards the patients. She actually had a strained relationship with her immediate superiors. Here is the interview I did with her:

**Q:** *How can you describe the work environment here?*

**A**: *the problem is that they don't consider me as someone who has done a speciality. They have stationed me here to do Pap smear they want statics every week and month end but they don't consider what I have studied*

I took notes when she explained the source of the uncordial relations after I had ended the audio recording;

> *She stated that the source of such uncordial relations ranged from her possessing a degree in oncology and failure to be recognised as an oncology nurse. She stated that the management would say out loud in the corridors that those who took degrees on their own (those not sponsored by the Department of Health) will not be recognised in the capacity on the qualifications stated on their certificates. She also stated that she was denied a*

> *junior nurse to work with to send samples to the laboratory since she has a problem with her leg* (field notes, 19/09/18).

This distanced her from her immediate superiors and this is how she sees them and how she explains their relationship:

> *…in Daniel 5 when king …saw the hand writing…you know what tekel means*…(it means to) *put you on the scale which means they have written tekel* (From Daniel 5 verse 25) *to me here at the back. I can't just sit and laugh with them I don't want to lie; the management have pained me*
>
> *…because I said I read the bible 1Pet5 vs 8 says* (quotes in Venda) *…it's not a lion, it roars like a lion then I say oh this management is roaring like a lion they want to discourage me to do my work. Me I will never hear them I will consider to my patient and my books of nursing say my first consideration in my work is a patient even if I go out and my husband is ill my first priority is patient…it's a pledge* (interview, Oncology nurse)

Yet, in the midst of all of it, she swears that;

> *…I will not leave my patients and follow what Lucifer says because on my side I am calling them Lucifer*
>
> *…now I told myself that if they direct me the thing that will help my patient I am going to do in peace but not in pieces but if they direct me the thing that they want me to be angry I will never listen to them* (interview, Oncology nurse)

So, even if the work environment was constraining and unfriendly, the interviewee would not direct her anger to the clientele of the services she provides. From street level bureaucracy

literature, for example Lipsky (1980) and Moyo (2010), inadequate resources or a hostile working environment causes street level bureaucrats to deviate from ideal work ethics as they vent their discontent on service users. This is correct and empirically based but not in all cases. The behaviour of street level bureaucrats should not always be understood by looking at the institutional sphere from which such behaviour is occurring. As seen in the interview with the oncology nurse, there are other institutional spheres whose schemas can accumulate resources (appeal to and shape human emotion and knowledge respectively) as postulated by Sewell (1992). The nurse extends logics or schemas of the religious institutional sphere to another. Her conduct cannot entirely be explained from within the institutional sphere she works in. Thus, in the quest for promoting a bottom-up approach to policy and practice, it is crucial to appreciate that whilst street level bureaucrats are influenced by work circumstances in making decisions and judgements, the seemingly independent judgements are structural in the sense that they are a writing reflecting cultural schemas of another sphere. More so, the outcomes of such judgements and decisions are not always negative and they do not ultimately lead to a disregard of orthodoxy or standardized procedures. We may therefore arrive at a different conclusion; that public healthcare workers are street level bureaucrats who exercise discretion and judgement influenced by cultural schemas and resources from elsewhere and the ensuing decisions may lead to desired outcomes as far as the relationship between the street level bureaucrat and the client is concerned.

This is a conclusion worth of all acceptance. The discussion with the next interviewee may buttress the intellectual contribution being generated here. One of the facility managers of a clinic in Kutama-Sithumule took to the ‘pulpit’ and offered a lengthy sermon on migration and migrants in South Africa and she was very emotional as she spoke:

**Q**: *What is your understanding of migration in South Africa and what are your views on them receiving public healthcare in South Africa?*

**A:** *Migrants are the people of God and they are hardworking and kind. They are just victims of circumstances. They should receive health care, why not? They are God’s people. You do not know what the future has so it is important to help those who are in difficult circumstances. God*

> *brought them here just to see if we will take care of them. The greatness of God should be seen in other people's lives. Do good, it shows God is in your heart. Can't you do a miracle to somebody? We are all blacks, why should we hurt each other? A migrant once came here smelling very bad and suffering from diarrhoea but I helped him and even gave him money to by some things* (Interview, Operational manager)

These sentiments were also echoed by another facility manager of another clinic in the area;

> *We are all from God. I don't mind them receiving health. Our ANC* (African National Congress leadership) *was also in exile at some point* (interview).

From the above, services are offered to migrants by street level bureaucrats who all testified that the conditions in which they were working were straining. As for Madombidzha facility, there were long queues of patients waiting to be attended to yet there were only two qualified nurses, the rest were helpers. I could see that the nursing staff including the facility manager was visibly exhausted. They all bemoaned the fact that they were understaffed; the same was said at Midoroni. Yet under all these circumstances, the interface between the health care worker and the clientele pointed to positive outcomes, at least according to what the interviewees said and what the interviewer observed. Although Lipsky's assertion that the environment within which street level bureaucrats work influences the interface between clients and the workers are empirically sound, in this case such assertions did not appear to have a firm ground. This justifies for the adoption of modified intellectual conception of street level bureaucrats and their clientele. In understanding decisions taken by workers in state facilities, it is crucial to acknowledge and look into many institutional spheres to which these workers are exposed to. In our case, religion proved to have a bearing on how workers interpreted circumstances. Still harnessing the work of Sewell (1992), it is clear that in one system there are multiple structures which have cultural schemas that can be applied in various spheres. Thus street level bureaucrats are structured bureaucrats, and the schemas of

this structure are foreign to their professional institutional sphere. Simply put, it is essential to look elsewhere other than the work environment to understand the behaviour of street level bureaucrats, some of which engender positive outcomes. Nevertheless, while religion proved to be a dominating factor in determining whether and how services are provided to migrants, it is not sustainable to rely on institutional inclinations of a street level bureaucrat.

In reframing or expanding the scope of the tenets of Street Level Bureaucracy by looking at cultural schemas from other institutional spheres other than the work place, it is also critical to look at personal experiences that shape how street level bureaucrats go about their everyday duties in bureaucracies. During the interviews, not only did health care workers point to religion as a buoy upon which their behaviour floats; some gave references to life experiences. In an interview with one of the nurses in Midoroni clinic, reference was given to her past life experiences and how they shape her perceptions of patients regardless of their place origin. She said;

> *My mom died when we were still young and they couldn't tell us what had happened to her but later on when I was doing my 1st year my sister told me my mom died of HIV …that hurt me so much …my mom was in denial so that motivated me to study nursing I swapped my courses I was doing BSC …from that time every time I see a patient I see my mom* (interview, Midoroni Nurse)

For this nurse the work environment or bureaucratic procedures were not primary drivers and determinants on her performance. The nurse acknowledged that directives of the nursing profession and her supervisor's instructions are some of the determinants of how she approaches her work. Yet, I am of the view that interpretations of what is said by an interviewee are of greater importance than what is literally said. From the above interview excerpt, it is evident that her past life experiences shape how she interprets and interact with directives. Whether she listens to directives or not is premised upon her goal to avenge for the untimely death of her mother, an event that motivated her to venture into the nursing profession. Framing this intellectually, it is clear that the tenets of Street Level Bureaucracy in its present form are epistemologically insufficient in explaining all of the behaviour of street level bureaucrats in their work stations. As advocated by Sewell in his theorizing of

structure, multiplicity of structures and transposability of cultural schemas from one institutional sphere to the other are crucial in explaining certain behaviours in certain institutional spheres (Sewell, 1992). The Midoroni nurse pays allegiance to another institutional sphere (family) other than the one where she executes her nursing duties. In this case the outcome is positive. The circumstances that happened in the confines of the institution of the family are key in modelling and shaping the nurse's conduct. This means that bureaucratic behaviour goes beyond circumstances within the bureaucratic setting. Thus, while Lipsky is very determined in wanting to prove ingenuity and innovatiness of street level bureaucrats and their independence from stated bureaucratic procedure, he ends up presenting a worker without other institutional orientations and one who only makes decisions within the confines of circumstances found in the bureaucratic setting where he/she performs his duties. However, this study has reshaped this scholarship and proved that the seemingly individual ingenuity is institutionalised and the institutions (cultural schemas and resources) are in some cases beyond the bureaucratic setting.

So what conclusions can be drawn in this section? That street level bureaucrats' independence from bureaucratic procedures may point us to dependence on schemas and resources from other institutional quarters. I conclude that street level bureaucrats' decision making should not only be understood and explained within the context these decisions are being made. While Lipsky might have made revisions in his 2010 edition, these revisions are only but a further buttressing of the original 1980 edition. His input in the bottom-up approach to policy remains useful in many ways but as this section proved, there is need to reorient our understanding of the meaning of agency and circumstances that determine how a street level bureaucrat behaves. Sewell's theorization of structure (1992) is very useful in the reshaping of Street Level Bureaucracy. Street level bureaucrats are agents whose agency is buoyed on cultural schemas and resources from other institutional spheres other than their bureaucratic work stations. Lastly, the provision of services to migrants relies heavily on the nurses' cultural and religious inclinations not on policy. It is hard to predict what happens if these inclinations shift.

## 6.3 Loving and hating at the same time: An antithesis in the provision of health care to migrants.

With the benefit of empirical evidence, I aver that views, perceptions or prejudices that people hold against another people do not always inform how the two peoples interact practically. The views on migrants by the nurses I interviewed were very consistent with those discussed in literature; that migrants are a burden to the national health and economy; that they are overwhelmingly many; and that they do not make meaningful contribution to the country's economy (Turton 2003; Grove & Zwi 2006; Amon and Todrys 2009; Harper and Raman 2008; Southern African HIV Clinicians Society & UNHCR, 2007; Vearey & Nunez 2010). But that is how far the concurrence goes. The nurses demonstrated that despite holding such views, they are guided by different ethics in the execution of their duties. This section uses Sewell's insights on structure, agency, duality and change (Sewell, 1992) to explain how cultural schemas from other institutional spheres, especially religion, can be transposed and transferred to the work setting thereby influencing how health care professionals interact in ways which are inconsistent with the negative views they hold regarding migrants.

All of the health care professionals I interviewed cited that migrants were many in South Africa generally and Makhado specifically. When asked what they think and understood about migration in South Africa and if their facilities host migrant patients, this is what they had to say:

> *A lot, mostly from Zimbabwe* (interview, Midoroni nurse)
>
> *Yes they are plenty in this area* (interview, Tshilwavhusiku acting facility manager)
>
> *They are many though we don't take statistic* (interview, Tshilwavhusiku nurse)

Whilst they said migrants are plenty, it is interesting that none could really give an estimate to qualify what they meant by plenty. Members of grassroots organisations I spoke to stated

that whilst migrants were there in the villages in Kutama-Sinthumule, they were few when compared to concentration in urban settings like Makhado where there are opportunities for economic advancement. The discourse that migrants are many concurs with what others have also discovered (Amon and Todrys, 2009; Harper and Raman 2008; Vearey and Nunez, 2010; Landau and Wa-Kabwe Segatti, 2009). This discourse is generated much from prevailing narratives in South Africa than it is from empirical observations. Kutama-Sinthumule is a rural place whose economic base does not attract many foreign nationals. But in a country where migrants are presented as contributing to the running down of the national economy and security; and at various points these narratives are broadcasted on prominent media platforms it is no surprise that even citizens in the hinterlands marry into this narrative.

As to how the above feeds into the way in which these government workers interact with migrants is perhaps a finding that digresses from what many have discovered. Many (Amon & Todrys, 2009, Grove & Zwi, 2006; Vearey, Nunez, Palmary 2009; Landau & Wa Kabwe-Segatti 2009; Vearey 2014) have come to the conclusion that the narrative that migrants are overwhelmingly many leads to an undesirable sequelae of the denial of public health care services to different migrant groups. However, in this study the health care professionals' behaviour seemed uninfluenced by such narratives. I asked them how the fact that migrants are many affects how they do their duties and they stated that they provide the services as is required by policy and in keeping with their conscience that acknowledges that migrants are human too. One nurse said;

> *I don't have a problem because when a person is sick is sick… We don't treat them differently because that person can't do anything but when we discuss we bring it up that we are having this challenge of foreigners because it's not in their hands (the foreigners) to control* (interview, Midoroni nurse)

When also asked about their views on migrants receiving health care in South Africa, one nurse stated;

> *Yes they should. Why not? They are human beings like us. Maybe it's because of my religion. I accommodate everyone as a person* (interview, Tshilwavhusiku acting Nurse in charge)

These narratives do not solidify what the literature cited above discovered. To explain this, a theorization of the behaviour of street level bureaucrats is useful. The quote that '*Maybe it's my religion'* may explain why, even after sharing the broader unempirical narrative that migrants are many, a bureaucrat still behaves in ways contrary to those expected of one holding such a view or narrative. Street level bureaucrats have discretion as stated by Lipsky (1980 and 2010) - they exercise judgements in various circumstances when dispensing services to their clientele. What is critical however is to acknowledge the unpredictability of these bureaucrats' responses especially when we consider that these workers subscribe to different cultural schemas and resources in different institutional spheres though these spheres may ultimately constitute a single social system. Sewell, in theorizing structure, agency and duality; states that agents can effect change, adjustments or reach compromises due to the fact that, though they may be domiciles of a single social system, they identify with certain schemas and resources (knowledge and emotional commitments) from other spheres and they possess the ability to extend and apply these into other spheres (Sewell, 1992). Thus, while the nurses I interviewed doubtlessly shared a common unempirical discourse that migrants are many, they however apply schemas from other institutions for example the religious institutional sphere whose resources calls for empathy, pity and sympathy.

Notwithstanding whether bureaucrats' unempirical perceptions translate into hostile treatment against those to whom such perceptions pertain, the nurses continued to demonstrate that they feel migration is a problem that required serious attention from the national government. Below is an extract of the interview conducted with a nurse in Madombidzha clinic:

> **Q**: *What is your understanding about migration in South Africa?*

> **A**: *It should be controlled because we are having challenges here influx, the influx of patients …these people are here they are getting all the treatment and then they are not paying anything …these people are not paying that yet they are many and then SA has got a large budget to provide whatever resources that are needed. So I think it's actually costly it's costing the government a lot of money that's why most of the time we have shortages of medications. Citizens of SA sometimes don't get the health that they need because of that shortage and it's caused by this amount of population we are facing here.* (Interview, Madombidzha nurse).

This response shared strikingly similar perceptions with those of one nurse in Midoroni clinic;

> *I feel like there should be something which should be done to control this mater …like they are under their country but they are here we give them medications they don't take medications from their countries then what happens to SA so I feel like these people maybe should pay for the services so that they should be forced to go to their countries and get those services so that at least when we give them here they should be adding something to our economy* (interview, Midoroni nurse).

These responses have vast similarities to what other scholars have also discovered. First, the coming of migrants to South Africa is understood as a threat. The term 'influx' used by the Madombidzha nurse concurs with what Turton (2003) refer to as 'threat metaphors' used to conceptualize migration, and these metaphors portrays migration as a threat warranting riddance. Second, both responses portrays migrants as a burden to the national fiscus and health facilities. The same was discovered by Vearey and Nunez (2010) and by Amon and Todrys (2009) who state that migrants are constantly portrayed as over burdening health facilities. Thirdly, the interviewees felt that migrants are not of economic value to the country. This contradicts Landau and Wa-Kabwe Segatti's (2009) and Ellis' (2008) discussion that

migrants contribute to national economic and social development. Migrants' skills, entrepreneurism and work ethic are some of the key points in these discussions.

These negative narratives have been discovered to ultimately lead to a disdain of migrants and migration which legitimizes denial of services to these populations (Amon and Todrys, 2009; Vearey and Nunez, 2010). However, in this case the health care professionals constantly reminded the interviewer that whilst they have this understanding (which is warped of course), they do not allow it to interfere it with their nursing duties. One nurse at Louis Trichardt Memorial hospital stated that;

> *Because I am a Christian I just say no nothing wrong…even our books of nursing they say forget about the discrimination if u see the patient* (interview, Oncology nurse)

She went on to say;

> *Me I am Pedi (*one of South Africa's ethnic groups)*, for the first time I came here they called me* <u>*vamutibiri*</u> (foreigner) *…they are calling me a foreigner because I am not a Venda that's why I am* <u>*simunye*</u> (one*) with those that are coming. If they see me they are coming from Messina the patients…when they see me they will be very much happy…because they also call me a foreigner* (interview, Oncology nurse)

Thus no matter how warped a view one might hold against someone or a people, it does not always manifest in the physical. People are not always prisoners of figments of their imaginations. But perhaps the methods used to obtain this data may fail to pick what happens practically on the ground. Interviews with nurses only might be insufficient to conclude how the migrant clientele is treated. Also, the fact that the interviewer was also a Zimbabwean migrant may generate what the interviewees consider to be desirable and acceptable responses. But then, when one goes to lengths spiritedly explaining the 'influx' by 'these

people' it leaves no doubt that the responses were not a mere pacification and massaging of the interviewer's emotions. So, why do these imaginations fail to translate into action? People subscribe to multiple ideals in different structural or institutional spheres (Sewell, 1992). They demonstrate remarkable abilities to apply certain schemas into different settings. Therefore, when seeking to explain the behaviour of street level bureaucrats it is important to acknowledge, with the benefit of Sewell, that social systems have multiple structures and institutional spheres to which agents may be connected. Discretion is framed by different cultural ideals and is not only confined to the environments within which these bureaucrats perform their duties.

Some interviewees however held the view that migrants are no different to South Africans. In an interview, one nurse stated that migrants have no problems, if they had any they are nothing but those also in the South African population. Here is her perception on migrants, specifically on crime:

> *The migrants have no problem. The problem is they are some, even South Africans especially where I am staying the crime is very high. We were having a meeting on Sunday all the residents and we agreed that we shouldn't look for foreigners*
>
> *...they were saying those foreigners because they are many in Eti Villa because they are staying in unfinished houses there. Me I just say no you are saying foreigners it's not foreigners only even the South Africans. They say why and I say the boy who is staying next to me (is) a Venda boy even though if it is raining* (he is always there) *...I just say all are the same* (interview, Oncology nurse)

Her views are contrary to what the large proportion of the population of host countries hold. Grove and Zwi (2006) speak of how host populations usually see foreign nationals as criminals and a threat to national security hence the calls for the securitization of borders. The views in the preceding interview are a sign that not all citizens hold migrants in contempt. However such hopes do not remain so high after what she said next;

> *What I just think being alone is why are they not paying R65 like us but when you ask those people they say if they pay R65 like us they are eating our*

> *money…they say they ought to pay more because they are not taxed.* (She now portrays her own perceptions)*When you go to Spar to buy grocery they say to me 14% VAT but for you* (she points to me) *you just buy. If you go with R1000* (South African currency) *my grocery will be lesser than yours* (interview, Oncology nurse)

In the first part of the interview extract, she seems to be referring to others but in the later part she shows she identifies with the same sentiment. Thus she showed mixed reactions about the topic on migration. On one hand she feels they are no different to South Africans, on the other she feels migrants have an unfair advantage over South Africans. This solidifies the findings in literature that migrants are seen as threats, not meaningfully contribute to the economy, and that they are a burden on the national economy and health. However, as stated before, these views do not always translate into bad treatment of the migrant patient. While the health care professionals may hold these views; the meaning of such views is moderated by other ideals from other institutional or structural spheres. They transfer certain cultural schemas from other institutional quarters, religion for example, and use them to weigh any views they may have on certain phenomena (Sewell, 1992). Therefore the ensuing action or response to these phenomenon may largely be traced not from the views held about that phenomenon, but from cultural ideals from institutional spheres they hold with awe especially religion.

This section has demonstrated that the views held by many of the street level bureaucrats interviewed are consistent with what other scholars have found. However, views held on a particular subject or people does not always mean those who hold such views will predictably behave in ways consistent with the views they hold. The behaviour of street level bureaucrats cannot be explained from one institutional sphere or only from the borders of the physical environment from with they do their duties. I have recruited the ideas of Sewell (1992) to explain inadequacies of some explanations given in literature regarding the behaviour of government workers who have direct physical contact with the people. Whilst it has been demonstrated how cultural ideals and schemas from other structural terrains, the next section will bring completeness to these intellectual contribution as it will prove beyond doubt that human behaviour is too complex to be understood within the bounds of a single institutional setting. Nevertheless, it is enough in this section to say that a consideration of human action

Vis a vis their mental framework is marred with contradistinctions and antithesis that require an appreciation of multiplicity of structures in their sphere of contact and transposabilty of cultural schemas from one platform to another.

# 7 Conclusion

The study has demonstrated that local level interventions that involve the state and NGOs are very complex in their nature. Evidence has shown that State-NGO collaborations in this study only went as far as allowing the NGOs to use some of the state facilities and making sure state workers who are certified to do certain functions do what NGO workers are not certified to do. Besides that, the collaboration's complexion and nature was not any different from what is discussed in literature. There exist mistrust between the state and NGOs with the latter emphasising the weaknesses and inadequacies of the former. It has also been shown that what motivates NGOs to provide services to target populations is the discovery of need and a quest to fulfil set goals within the organisation. The state did not appear to have direct influence on what these organisations pursue. NGOs pride themselves in being located in the communities and this has a potential danger of making the NGOs gatekeepers in many ways. Whilst funding proved to have some measure of sway in determining projects and goals pursued, this sway was only seen as acceptable only as far as it corresponds with the primary objectives of the organisations involved. It is also beyond doubt that interventions on migration by organisations involved relies much on sentiment, volition and empathy of the organisational actors as opposed to policy or solid programmes.

The study has also shown that the knowledge, beliefs and views of street level bureaucrats (nurses) on migrants are consistent with those in literature on migration and health. The beliefs that migrants are many; travel for health seeking purposes; are a burden to the country's health facilities; and that they make no contribution to the country's economy were consistent with the views of the nurses interviewed. The study has also shown that policies in the health sector are not a significant determinant of what the nurses do and how they do it. More importantly, the study made an intellectual contribution in explaining the source of the behaviour of street level bureaucrats. While the study also used the Street Level Bureaucracy theory in theorising the behaviour of healthcare providers, the use of The Institutional Theory and Sewell's ideas has shown that the behaviour of street level bureaucrats can be explained and understood beyond the bureaucratic sphere. People have the ability to fetch cultural schemas from certain institutions to make sense of circumstances in other institutions.

While migrants access services at the local level, they only access services that are designed for sedentary populations. Nothing in the field showed programmes that were designed taking

into consideration the needs of mobile populations. Migrants' health is catered for by a system that does not consider their needs. The health of migrants is at the mercy of the empathy and will of the provider and these are unsustainable due to their unpredictability. To that end, it can be concluded that what largely influences interventions at the grassroots is more to do with what the individuals on the ground decide to do based on their discretion and innovation than external directives and influences of any sort.

* * *

# References

Acharya, B., Maru, D., Schwarz, R., Citrin, D., Tenpa, J., Hirachan, S., Basnet, M., Thapa, P., Swar, S., Halliday, S. and Kohrt, B., 2017. Partnerships in mental healthcare service delivery in low-resource settings: developing an innovative network in rural Nepal. *Globalization and health*, *13*(1), p.2.

Albrow, M., 1970. *Bureaucracy*. London, Macmillan Press.

Amon, J.J. and Todrys, K.W., 2008. Fear of foreigners: HIV-related restrictions on entry, stay, and residence. *Journal of the International AIDS Society*, *11*(1), p.8.

Anarfi, J.K., 2005. Reversing the spread of HIV/AIDS: What role has migration? *International Migration and the Millennium Development Goals*, p.99.

Batley, R. and Mcloughlin, C., 2010. Engagement with non-state service providers in fragile states: reconciling state-building and service delivery. *Development Policy Review*, *28*(2), pp.131-154.

Batley, R., 2006. Engaged or divorced? Cross-service findings on government relations with non-state service-providers. *Public Administration and Development: The International Journal of Management Research and Practice*, *26*(3), pp.241-251.

Batley, R., 2006. Engaged or divorced? Cross-service findings on government relations with non-state service-providers. *Public Administration and Development: The International Journal of Management Research and Practice*, *26*(3), pp.241-251.

Bemelmans-Videc, M.L., Rist, R.C. and Vedung, E.O. eds., 2011. *Carrots, sticks, and sermons: Policy instruments and their evaluation* (Vol. 1). Transaction Publishers.

Bourdieu, P. and Nice, R., 1977. *Outline of a Theory of Practice* (Vol. 16). Cambridge: Cambridge university press.

Bratton, M., 1989. Beyond the state: Civil society and associational life in Africa. *World politics*, *41*(3), pp.407-430.

Chen, J., 2011. Internal migration and health: re-examining the healthy migrant phenomenon in China. *Social Science & Medicine*, *72*(8), pp.1294-1301.

Circular labour migration and mortality in rural South Africa. *Scandinavian*

Clark, S.J., Collinson, M.A., Kahn, K., & Tollman, S.M., 2007. Returning Home to Die:

Collinson, M., Vearey, J., Bocquier, P., Drimie, S., Quinlan, T., Twine, W., 2010. Reaching the invisible: Hidden links of ill health between South Africa's cities and rural areas.

Constitution, S.A., 1996. Bill of Rights. *Retrieved November*, *12*, p.2013.

Crush, J., Williams, B., Gouws, E. and Lurie, M., 2002. Spaces of vulnerability: migration and HIV/AIDS in Southern Africa. *Migration Policy*.

De Visser, J., 2005. Developmental local government: A case study of South Africa. Intersentia nv.

Deane, K.D., Parkhurst, J.O. and Johnston, D., 2010. Linking migration, mobility and HIV. *Tropical Medicine & International Health*, *15*(12), pp.1458-1463.

Dickinson, C. and Buse, K., 2008. Understanding the politics of national HIV policies: the roles of institutions, interests and ideas. HLSP institute.

El-Khatib, Z., Scales, D., Vearey, J. and Forsberg, B.C., 2013. Syrian refugees, between rocky crisis in Syria and hard inaccessibility to healthcare services in Lebanon and Jordan. *Conflict and health*, *7*(1), p.18.

Erasmus, E., 2017. *Street-level Bureaucracy*. Guidance Note 5. Retrieved July 18, 2017, from http://www. hpsa-africa. org/images/Street_level_bureaucracy_final_for_web. pdf.

Feldman, A., 1999. The role of conversation in collaborative action research. *Educational action research*, *7*(1), pp.125-147.

Fourie, P., 2006. The Political management of HIV and AIDS in South Africa: one burden too many? Springer.

Friedman, S. and Kihato, C., 2004. South Africa's Double Reform: Decentralization and the Transition from Apartheid. *Decentralization, Democratic Governance, and Civil Society in Comparative Perspective: Africa, Asia and Latin America*, pp.141-189.

Gauvin, F. P., 2014. Understanding Policy Developments and Choices Through the" 3-i" Framework: Interests, Ideas and Institutions. F. Benoit, & M. Jacques (Eds.).

Giddens, A., 1976. New rules of sociological method: A positive critique of interpretive sociologies.

Giddens, A., 1979. Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis.

Giddens, A., 1981. A contemporary critique of contemporary materialism. Volume 1: power, property and the state.

Giddens, A., 1984. The Constitution of Society: Outline of the Theory of Structuration. Berkeley and Los Angeles: University of California Press

Gilson, L., Sen, P.D., Mohammed, S. and Mujinja, P., 1994. The potential of health sector non-governmental organizations: policy options. *Health Policy and planning*, *9*(1), pp.14-24.

Government Gazette, 2004, the National Health Act, Republic of South Africa, Volume 469

Grimwood A, Crew M, Betteridge D. 2000. HIV/AIDS – current issues. In: Ntuli A, Crisp N, Clarke E, Barron P (eds). South African Health Review 2000. Durban: Health Systems Trust.

Grove, N.J. and Zwi, A.B., 2006. Our health and theirs: forced migration, othering, and public health. *Social science & medicine*, *62*(8), pp.1931-1942.

Gubrium, J.F. and Holstein, J.A., 2002. Handbook of interview research: Context and method. Sage.

Hall, P.A. and Taylor, R.C., 1996. Political science and the three new institutionalisms. *Political studies*, *44*(5), pp.936-957.

Hall, P.A., 1997. The role of interests, institutions, and ideas in the comparative political economy of the industrialized nations. *Comparative politics: Rationality, culture, and structure*, pp.174-207.

Hall, R., Wisborg, P., Shirinda, S. and Zamchiya, P., 2013. Farm workers and farm dwellers in Limpopo Province, South Africa. *Journal of Agrarian Change*, *13*(1), pp.47-70.

Hammersley, M. and Atkinson, P., 1983. *Ethnography: Principles in practice*. Routledge.

Hanson, K. and Berman, P., 1998. Private health care provision in developing countries: a preliminary analysis of levels and composition. *Health policy and planning*, *13*(3), pp.195-211.

Hunter, M., 2010. Beyond the male-migrant: South Africa's long history of health geography and the contemporary AIDS pandemic. *Health & Place*, *16*(1), pp.25-33.

Hupe, P. and Hill, M., 2007. Street-Level bureaucracy and public accountability. *Public administration*, *85*(2), pp.279-299.

John, P. and Cole, A., 1998. Urban Regimes and Local Governance in Britain and France Policy Adaption and Coordination in Leeds and Lille. *Urban Affairs Review*, *33*(3), pp.382-404.

Journal of Public Health, 35(Suppl. 69), 35-44.

Kark, S.L., 1949. The Social Pathology of Syphilis in Africans. *South African medical journal*, *23*(5), pp.77-84.

Kautzky, K. and Tollman, S.M., 2008. A perspective on Primary Health Care in South Africa: Primary Health Care: in context. *South African health review*, *2008*(1), pp.17-30.

Kelly, K. and van Donk, M., 2009. Local-level responses to HIV/AIDS in South Africa. In *HIV/AIDS in South Africa 25 Years On* (pp. 135-153). Springer New York.

Kelly, M., 1994. Theories of justice and street-level discretion. *Journal of Public Administration Research and Theory*, *4*(2), pp.119-140.

Landau, L.B. and Segatti, A.W.K., 2009. Human development impacts of migration: South Africa case study.

Legard, R., Keegan, J. and Ward, K., 2003. In-depth interviews. *Qualitative research practice: A guide for social science students and researchers*, pp.138-169.

Leon, N., Schneider, H. and Daviaud, E., 2012. Applying a framework for assessing the health system challenges to scaling up mHealth in South Africa. *BMC medical informatics and decision making*, *12*(1), p.123.

Levi, M., 1997. A model, a method, and a map: Rational choice in comparative and historical analysis. *Comparative politics: Rationality, culture, and structure*, *28*, p.78.

Lipsky, M., 1980. Street level bureaucracy: The Dilemmas of Individuals in Public Service. New York, Russell Sage.

Loevinsohn, B. and Harding, A., 2005. Buying results? Contracting for health service delivery in developing countries. *The Lancet*, *366*(9486), pp.676-681.

Lomas, J., Culyer, T., McCutcheon, C., Law, S. and Tetroe, J., 2005. -Final Report-Conceptualizing and Combining Evidence for Health System Guidance.

Lurie, M., 2000. Migration and AIDS in southern Africa: a review. *South African Journal of Science*, *96*(6), pp.343-347

Lurie, M.N., 2006. The epidemiology of migration and HIV/AIDS in South Africa. *Journal of Ethnic and Migration Studies*, *32*(04), pp.649-666.

MacPherson, D.W. and Gushulak, B.D., 2001. Human mobility and population health: new approaches in a globalizing world. *Perspectives in Biology and Medicine*, *44*(3), pp.390-401.

Manor, J. and World Bank, 1999. The political economy of democratic decentralization.

Matjila, M.J., Hoosen, A.A., Stoltz, A. and Cameron, N., 2008. STIs, HIV and AIDS and TB: Progress and Challenges. *South African health review*, pp.89-10

Matland, R.E., 1995. Synthesizing the implementation literature: The ambiguity-conflict model of policy implementation. *Journal of public administration research and theory*, *5*(2), pp.145-174

Maynard-Moody, S. and Musheno, M., 2000. State agent or citizen agent: Two narratives of discretion. *Journal of Public Administration Research and Theory*, *10*(2), pp.329-358.

Maynard-Moody, S.W. and Musheno, M.C., 2003. *Cops, teachers, counselors: Stories from* University of Michigan Press. *the front lines of public service*.

Mead, G.H. and Miller, D.L., 1982. *The individual and the social self*. Chicago: University of Chicago Press

Moore, S.T., 1987. The Theory of Street-Level Bureaucracy A Positive Critique. *Administration & Society*, *19*(1), pp.74-94.

Moore, S.T., 1990. Street-level policymaking: characteristics of decision and policy in public welfare. *The American Review of Public Administration*, *20*(3), pp.191-209.

Moyo, K., 2010. Street level interface: the interaction between health personnel and migrant patients at an inner city public health facility in Johannesburg (Doctoral dissertation).

Najam, A., 1995. Learning from the literature on policy implementation: a synthesis perspective.

Nattrass, N., 2004. *The moral economy of AIDS in South Africa*. Cambridge University Press.

Ngwena, C. and Van Rensburg, H.C.J., 2002. HIV/AIDS policies since the advent of the epidemic in South Africa: review and appraisal. *Strengthening local government and civic responses to the HIV/AIDS epidemic in South Africa. Bloemfontein: Centre for Health Systems Research & Development*.

Peters, B.G., 2002. The politics of tool choice. *The tools of government: A guide to the new governance*, pp.552-564.

Pomey, M.P., Morgan, S., Church, J., Forest, P.G., Lavis, J.N., McIntosh, T., Smith, N., Petrela, J., Martin, E. and Dobson, S., 2010. Do provincial drug benefit initiatives create an effective policy lab? The evidence from Canada. *Journal of health politics, policy and law*, *35*(5), pp.705-742.

Pope, C., S. Ziebland, et al. (2000). "Qualitative research in healthcare: Analysing qualitative data." BMJ **320**: 114-116.

SADC, 2009. Directorate for Social and Human Development and Special Programs. SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC Region: Final Draft April 2009

Schneider, H., 2002. On the fault-line: the politics of AIDS policy in contemporary South Africa. *African Studies*, *61*(1), pp.145-167.

Schneider, H., Hlophe, H. and van Rensburg, D., 2008. Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Health policy and Planning*, *23*(3), pp.179-187.

Sewell Jr, W.H., 1992. A theory of structure: Duality, agency, and transformation. *American journal of sociology*, *98*(1), pp.1-29.

Siddle, A. and Koelble, T.A., 2013. The failure of decentralisation in South African local go

Skjæraasen, M., 2008. Velgerflukten [Flight of voters]. A-Magasinet [weekly magazine by Norwegian newspaper Aftenposten],28 March: 24–32.

South African National AIDS Council, 2012. *National strategic plan on HIV, STIs and TB, 2012-2016*. South African National AIDS Council.

Steytler, N., 2003. Federal homogeneity from the bottom up: provincial shaping of national HIV/AIDS policy in South Africa. *Publius*, pp.59-74.*vernment: Complexity and unanticipated consequences*. Juta Academic.

Suphanchaimat, R., Sommanustweechai, A., Khitdee, C., Thaichinda, C., Kantamaturapoj, K., Leelahavarong, P., Jumriangrit, P., Topothai, T., Wisaijohn, T. and Putthasri, W., 2014. HIV/AIDS health care challenges for cross-country migrants in low-and middle-income countries: a scoping review. *HIV/AIDS (Auckland, NZ)*, *6*, p.19.

Tere, R. 2006. Qualitative data analysis. New York, http://e-articles.info/e/a/title/QUALITATIVE-DATA-ANALYSIS/.

Vearey, J. (2011b). Migration and Health in South Africa: Implications for Development. In A. Segatti, & L. Landau (Eds.), *Contemporary Migration to South Africa. A Regional Development Issue*. Washington D.C.: The World Bank.

Vearey, J., 2014. Healthy migration: a public health and development imperative for south (ern) Africa. *SAMJ: South African Medical Journal*, *104*(10), pp.663-664.

Vearey, J., 2014. Healthy migration: A public health and development imperative for south (ern) Africa. *SAMJ: South African Medical Journal*, *104*(10), pp.663-664

Vearey, J., 2018. Moving forward: why responding to migration, mobility and HIV in South (ern) Africa is a public health priority. *Journal of the International AIDS Society*, *21*, p.e25137.

Vearey, J., Núñez, L. and Palmary, I., 2009. *HIV, migration and urban food security: exploring the linkages*. University of the Witwatersrand.

Vearey, J., Richter, M., Núñez, L. and Moyo, K., 2011. South African HIV/AIDS programming overlooks migration, urban livelihoods, and informal workplaces. *African Journal of AIDS Research*, *10*(sup1), pp.381-391.

Walker, L. and Gilson, L., 2004. 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social science & medicine*, *59*(6), pp.1251-1261.

Walls, H.L., Vearey, J., Modisenyane, M., Chetty-Makkan, C.M., Charalambous, S., Smith, R.D. and Hanefeld, J., 2016. Understanding healthcare and population mobility in southern Africa: The case of South Africa. *SAMJ: South African Medical Journal*, *106*(1), pp.14-15.

Weine, S.M. and Kashuba, A.B., 2012. Labor migration and HIV risk: a systematic review of the literature. *AIDS and Behavior*, *16*(6), pp.1605-1621.

Weissert, C.S., 1994. Beyond the organization: The influence of community and personal values on street-level bureaucrats' responsiveness. *Journal of Public Administration Research and Theory*, *4*(2), pp.225-254.

Whyte, W.F., 1979. On making the most of participant observation. *The American Sociologist*, pp.56-66.

Wickramage, K., Vearey, J., Zwi, A.B., Robinson, C. and Knipper, M., 2018. Migration and health: a global public health research priority. *BMC public health*, *18*(1), p.987.

Witternberb, M., 2006. Decentralisation in South Africa, in Bardhan, P and Mookerjee, D (eds). Decentralisation and local government in developing countries: a comparative perspective. Cambridge, MA: MIT Press, 329-356.

Wouters, E., Van Rensburg, H.C.J. and Meulemans, H., 2010. The National Strategic Plan of South Africa: what are the prospects of success after the repeated failure of previous AIDS policy? *Health policy and planning*, *25*(3), pp.171-185.

# APPENDICES

## Appendix 1: Information Sheet for TVEP Management

**Title of research project:**

Interests, Ideas, and the Workspace: towards understanding local level interventions on sexual and reproductive health targeting key populations in Kutama-Sinthumule villages, Limpopo South Africa

**Research Protocol number:** H17/08/23
**Student name:** Learnmore Mvundura
**Student email:** learnmoremvundura@gmail.com
**Student contact number:** 0845987073

**Supervisor name:** Jo Vearey (Prof)
**Supervisor email:** jovearey@gmail.com
**Supervisor contact number:** 072 392 7034

**University of the Witwatersrand Research Ethics Committee (non-medical) contact:**

1 Lucille.Mooragan@wits.ac.za
011 717 1408

---

Hello! My name is Learnmore Mvundura and I am conducting a research study that aims to investigate the factors that motivates grassroots organizations to do projects locally like the one you are doing.

I would like to invite you to take part in this study as it will help me to understand the factors that influence grassroots organizations to be involved in projects at a local level.

**What does this study entail?**

Your participation in this study will include the following:

- Mapping out exercise in which I expect you to assist me in locating the various stakeholders that you have mobilized for this project

- Approximately one hour interview in which I will be asking you questions that will hopefully give me an understanding of the factors that influenced you to do this project

**Risks:** I do not anticipate any risks in this study. I will ask you questions about this organization. If for any reason you are uncomfortable you can skip a question or chose to stop the interview at any time and there are no penalties in doing so. If any of the topics discussed in the interview upset you, feel free to terminate the interview.

**Benefits:** You may not receive any direct benefit from participating in this study. But, this research will help me to understand factors that influence grassroots organizations to take part in the project as the one you are doing

**Costs:** There are no direct costs associated with this research project.

The information that will be collected is purely for research purposes and to learn more about factors motivating grassroots organizations to do interventions locally.

The information that you share with me may be written up in research reports. I will NOT use any of your personal. I will try by all means to make you unidentifiable in the research report. However, since you will be identified as 'management' in the research report, chances are that your identity might be traceable since someone might track the people who were in the management at the time the research was conducted. But since I will be interviewing other members of management, it will not be practical for anyone to track response to a particular individual.

Your responses may be made available in an anonymised format for a variety of subsequent purposes, including for future teaching and research projects.

Participation is completely voluntary; you are under no obligation to take part in this project.

You may withdraw from this project at any stage; this will not affect you in any way.

- **Do you have any questions?**

- **Would you like to go ahead with being part of this research project?**

## Appendix 2: INFORMED CONSENT: TVEP Management

**Tittle of research project:** Interests, Ideas, and the workspace: towards understanding local level interventions on HIV and STIs targeting migrants in Kutama-Sinthumule, Limpopo South Africa

**Student name:** Learnmore Mvundura
**Student email:** learnmoremvundura@gmail.com
**Student contact number:** 0845987073

**Supervisor name:** Jo Vearey (Prof)
**Supervisor email:** jovearey@gmail.com
**Supervisor contact number:** 072 392 7034

**University of the Witwatersrand Research Ethics Committee (non-medical) contact:**

2 Lucille.Mooragan@wits.ac.za
011 717 1408

| | **Tick your response** | |
|---|---|---|
| I have read and understood the participant information sheet, and have had the opportunity to ask questions. | **Yes** | **No** |
| | | |
| I understand I am no under obligation to take part in this study | | |
| I understand I have the right to answer and not to answer particular questions for whatever reasons | | |
| I understand this research is for academic purposes and that through publication my contribution will be made available to the public | | |
| I understand I have the right to withdraw from the study for whatever reason | | |
| I understand that all information will be confidential and my responses anonymised. It has been explained that anonymity might not be fully guaranteed. | | |

**FOR VERBAL CONSENT**

**PARTICIPANT**:

---

Printed Name of Participant Date

**Person who sought consent (research assistant)**

- **I Learnmore Nvundura herewith confirm that the above participant has been fully informed about the study and has given verbal consent to participate as indicated above.**

---

Printed Name Signature Date

**FOR WRITTEN/SIGNED CONSENT**

**PARTICIPANT**:

---

Printed Name of Participant Date

- **I herewith confirm that I have been fully informed about the study and have given consent to participate as indicated above.**

---

Printed Name Signature Date

## Appendix 3: Consent form for audio-taping of the interview: TVEP Management

For data analysis purposes I request to audio tape this interview. The tapes will be destroyed two years after any publication or six years if no publications are made.

| | **Tick your response** | |
|---|---|---|
| | **Yes** | **No** |
| I accept for this interview to be audio taped | | |
| I accept the use of verbatim (direct) quotes from this interview | | |

…… ……..

……../……/……

Name Signature Date

## Appendix 4: Information Sheet for Nurse providing services to migrants

Wits University, 1 Jan Smuts Avenue, Braamfontein 2000

Dear Sir/Madam

My name is Learnmore Mvundura and I am a Masters student in Migration and Displacement at Wits University in Johannesburg. As part of my studies I have to undertake a research project, and I am investigating **Interests, Ideas and the Workplace seeking to understand local level interventions on sexual and reproductive health targeting key populations in Kutama-Sinthumule villages, Limpopo, South Africa.** The aim of this research project is to find out what influences local level organizations to provide sexual and reproductive health services to key populations including migrants, and whether and how the working environment influences how these services are provided to these key populations.

As part of this project I would like to invite you to take part in an interview at your work place. This activity will involve answering questions specifically on whether and how the working environment affect the way you provide sexual and reproductive health services to key populations particularly migrants and will take around forty minutes to one hour.With your permission, I would also like to record the interview using a digital device. The audio recordings will be stored in a password protected computer and will only be accessible to me and my supervisor.

You will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for not participating. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential and anonymous since I will not be asking for your name or any identifying information. The information you give to me will be held securely in a password protected computer and not disclosed to anyone else. I will be using a pseudonym (false name) to represent your participation, in my final research report. If you experience any distress or discomfort, we will stop the interview or resume another time

If you have any questions afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you upon request. If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (non-medical), telephone + 27(0)11 717 1408, email hrec-medical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Yours sincerely,
Learnmore Mvundura

Researcher: Learnmore mvundura, learnmoremvundura@gmail.com, +27(0)84 598 7073
Supervisor: Jo Vearey, jovearey@gmail.com, +27(0)72 392 7034

## Appendix 5: INFORMED CONSENT: Nurses

**Tittle of research project:** Interests, Ideas, and the workspace: towards understanding local level interventions on HIV and STIs targeting migrants in Kutama-Sinthumule, Limpopo South Africa

**Student name:** Learnmore Mvundura
**Student email:** learnmoremvundura@gmail.com
**Student contact number:** 0845987073

**Supervisor name:** Jo Vearey (Prof)
**Supervisor email:** jovearey@gmail.com
**Supervisor contact number:** 072 392 7034

**University of the Witwatersrand Research Ethics Committee (non-medical) contact:**

3 Lucille.Mooragan@wits.ac.za
011 717 1408

| | **Tick your response** | |
|---|---|---|
| I have read and understood the participant information sheet, and have had the opportunity to ask questions. | **Yes** | **No** |
| | | |
| I understand I am no under obligation to take part in this study | | |
| I understand I have the right to answer and not to answer particular questions for whatever reasons | | |
| I understand this research is for academic purposes and that through publication my contribution will be made available to the public | | |
| I understand I have the right to withdraw from the study for whatever reason | | |
| I understand that all information will be confidential and my responses anonymised. It has been explained that anonymity might not be fully guaranteed. | | |

**FOR VERBAL CONSENT**

**PARTICIPANT**:

---

Printed Name of Participant Date

**Person who sought consent (research assistant)**

- **I Learnmore Nvundura herewith confirm that the above participant has been fully informed about the study and has given verbal consent to participate as indicated above.**

---

Printed Name Signature Date

**FOR WRITTEN/SIGNED CONSENT**

**PARTICIPANT**:

---

Printed Name of Participant Date

- **I herewith confirm that I have been fully informed about the study and have given consent to participate as indicated above.**

---

Printed Name Signature Date

## Appendix 6: Consent form for audio-taping of the interview: Nurses

For data analysis purposes I request to audio tape this interview. The tapes will be destroyed two years after any publication or six years if no publications are made.

| | **Tick your response** | |
|---|---|---|
| | **Yes** | **No** |
| I accept for this interview to be audio taped | | |
| I accept the use of verbatim (direct) quotes from this interview | | |

…… ……..

……../……./……

Name Signature Date

## Appendix 7: Wits University Ethics Clearance Certificate: Non-medical

Research Office

**HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)**
R14/49 Mvundura

| | |
|---|---|
| **CLEARANCE CERTIFICATE** | **PROTOCOL NUMBER: H17/08/23** |
| **PROJECT TITLE** | Interests, ideas, and the workspace: towards understanding local level sexual and reproductive health (SRH) interventions targeting migrants in Kutama-Sinthumule, Limpopo South Africa |
| **INVESTIGATOR(S)** | Mr L Mvundura |
| **SCHOOL/DEPARTMENT** | Social Sciences/ |
| **DATE CONSIDERED** | 18 August 2017 |
| **DECISION OF THE COMMITTEE** | Approved |
| **EXPIRY DATE** | 23 October 2020 |

**DATE** 24 October 2017 **CHAIRPERSON** J. Knight
(Professor J Knight)

cc: Supervisor : Professor J Vearey

**DECLARATION OF INVESTIGATOR(S)**

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ _____/_____/_____
Signature Date

**PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES**

## Appendix 8: Limpopo Provincial Department of Health Approval Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Stander SS (015 293 6650) Ref:4/2/2

Mvundura L
1104, 60 Gerald Sekoto Street
Newtown, Johannesburg
2001

HUMAN RESEARCH ETHICS COMMITTEE

Greetings,

RE: Interests, ideas and the workspace: towards understanding local level sexual and reproductive health (SRH) interventions targeting migrants in Kutama-Sinthumule, Limpopo Province South Africa

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

Head of Department

08/02/2018
Date

18 College Street, Hospitalpark, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6001, Fax: (015) 295 1220 Website: http://www.limpopo.gov.za

**Appendix 9: Vhembe District Approval Letter**

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OFHEALTH**
**VHEMBE DISTRICT**

Ref: 5/5/6
Enq: Mavari MMR
Date: 05June 2018

Dear Sir/ Madam : Mvundura L

**PERMISSION TO CONDUCT RESEARCH IN interest, ideas and the workplace: towards understanding local level sexual and reproductive health (srh) intervention targeting migrants in kutama sinthumule, limpopo province south vhembe**

1. The above matter bears reference
2. Your letter received on the 05/06/2018 requesting for permission to conduct research in our facilities is hereby acknowledged
3. The District has no objection to your request.
4. Permission is therefore granted for the request to be conducted within Vhembe District.
5. You are however advised to make the necessary arrangements with the facilities concerned.
6. Wishing you success in your research in Vhembe health facilities.

DISTRICT CEO/ DIRECTOR ..... DATE .....

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4558 (Social Dev.) Fax (015) 962 2274/4928
Old Parliamentary Building Tel: (015) 962 1818, (015) 962 1862, (015) 962 754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2873, (015) 962 227

*The heartland of Southern Africa - development is about peo*

## Appendix 4: Interview Guide – Grassroots Organisations' Management Staff

The organisation's interests in providing health services to migrants

1. I understand that in this project you seek target what you call key populations. Who are key populations?
2. The funding from Margaret Hurley has indicated migrants as one of the several key populations. Are you targeting migrants and how are you doing so?
3. Do you find it necessary to provide sexual and reproductive health services to migrants? Why?
4. In the past projects how have you been defining key populations? Have migrants been among these key populations and why?

Engagement of other stakeholders

5. Who are other stakeholders that you have engaged and why the choice of these?
6. What factors determine the choice of stakeholders mobilised?
7. As an organisation, to whom do you feel obligated when framing your programmes?

Organisation's position on government (national or local) policies

8. Are there national level policies (or provincial) that speak to the issues you seek to address are you aware of? What are these?
9. What place do these policy documents have in the framing of your programmes?
10. Are you as an organisation bound by the stipulations or recommendations in these policy documents?
11. If no, to who are you obligated?
12. If yes, to what extend are you open to the stipulations, observations and recommendations in these policy directives?
13. Is there a point where the organisation sees national policy to be in contravention of what they believe should be done and how it should be done? What do you do as an organisation in such cases?

The role of funders in the framing of projects

14. Is this project self-funded by TVEP?

15. If not, besides material resources injected into this project by funders, in what other ways are the funders involved?
16. What are the funders' expectations as far as this project is concerned?
17. How do you balance the funders' expectations with yours as an organisation and those of the government (national or provincial)
18. Who do you think has the greatest say on how a project should be framed?
19. What determines which project gets funding?
20. Are there points when you as an organisation conflict with funders? If yes, on what points do you conflict and what ultimately happens as far as any project is concerned?

Organisational precedence

21. As an organisation, are there rules and norms that shape how you approach/do your projects? Is there a defined pattern you follow in doing your projects? What is this pattern, rules or norms?
22. When you engage other stakeholders (funders or the government), what does it mean for your organisational pattern/ way of doing things?
23. Are you willing to alter this pattern and how far are you willing to alter it? Is the pattern flexible?
24. Do you find yourself in a situation where stakeholders' expectations are in conflict with your organisational way of doing things? What do you do in such cases?
25. In light of the above, can you say your organisation follows a predetermined path or that it adjusts to suit the circumstances?

## Appendix 4: Interview Guide: Public Healthcare Professionals

**Ideas on migration (…and health)**

1. What is your job description and for how long have you been working here?
2. What do you understand about migration in general in South Africa? Any statistics? Its impact?
3. What is your understanding about migration and health in South Africa?
4. Is migration a problem or benefit in South Africa? Why?
5. Do you think migrants have an impact on the South African health system? If yes what is this impact?
6. What do you think about migrants receiving health care in South Africa?
7. What is required for a foreign national to access health care?

**Interaction with the migrant patient**

8. What are your experiences with migrants both inside and outside the workspace?
9. What is the profile of patients you attend to in a day?
10. Of the patients you attend to, are there any problem patients? Who are these and what would they have done to qualify as such? Does nationality plays part in being a problem patient?
11. What is your personal response to these problem patients?

**The working environment and the nurses' discretion.**

12. How can you describe the working environment in this facility?
13. Can you describe to me what your average working day looks like?
14. In your own view, does the facility have enough resources (human and medical), and what do you understand by 'enough resources'?

15. How does what you have described above affect how you do your duties?
16. I understand this facility is working with TVEP to target certain populations including migrants, what do you think about the project?
17. Is what TVEP doing in partnership with this facility agreeing with what you think should/should not be done?
18. In the event that the project conflicts with what you think, what do you do? What impact does this have on how you perform your duties?
19. Are there situations where superiors demand of you what conflicts with your views on a certain issue? What are these situations and what do you do?
20. What do you think about directives from above (within the clinic, provincially or nationally)? Are they doable/practical? If not, what do you do when asked to do something you think is not practical or contrary to your views? Can you give examples you remember?
21. Are there situations where you once did something that you think was the right thing to do though it was not what you were expected to do? If yes, explain.
22. In your own view, who/what can you say influences how you do your duties?
23. Do you have any questions or do you feel you have anything to add on what we have been discussing?