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EXAMINING HEALTH SYSTEM RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

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A thesis completed by published work

Submitted to the School of Public Health, Faculty of Health Sciences,

University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of

Doctor of Philosophy

November 2021

DECLARATION

This thesis is submitted in the integrating narrative format of published work, approved by the Faculty of Health Sciences.

I, Janine Anthea White, declare that this thesis is my original work. It is being submitted for the degree of Doctor of Philosophy in the University of the Witwatersrand, Johannesburg. This thesis has not been submitted before for any degree or examination at this or any other University. I am aware that plagiarism is wrong, and I confirm that this thesis is my own unaided work except where I have explicitly indicated otherwise. I have read the sections on referencing and plagiarism in the Wits Plagiarism Policy. I have followed the required conventions in referencing the thoughts and ideas of others. I understand that the University of the Witwatersrand may take disciplinary action against me, including suspension or permanent expulsion, if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: 

Janine Anthea White

Date: 17 November 2021

DEDICATION

This PhD is dedicated to Mari Sabrina Erentzen and Hannah Isla Jacobs, loves of my life.

PRESENTATIONS ARISING FROM THIS PHD

1. **White, J.A. and Rispel, L.C.** "They come in a bus": perspectives of health care providers on migrants and refugees utilising public health care facilities in South Africa. **Presentation at the Epidemiology and Public Health (EPH) seminar, University College London Research Department of Epidemiology and Public Health, London**, October 31st, 2018.
2. **White, J.A., Blaauw D., and Rispel, L.C.** "Migrants and refugees are people like everyone else": Perspectives of health care providers in Gauteng public health care facilities on social exclusion**. Oral presentation at the 15th Public Health Association of South Africa (PHASA) conference, Cape Town,** 16 September 2019.
3. **White, J.A. and Rispel, L.C.** Contested and nervous spaces: Exploring the environment of health care provision for migrants in the Gauteng province of South Africa**. Oral presentation at the University of the Witwatersrand, School of Public Health Biennial Research Day, Johannesburg,** 8-9 September 2021.

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1. **White, J.A.**, Blaauw, D., & Rispel, L.C. (2020). Social exclusion and the perspectives of health care providers on migrants in Gauteng public health facilities, South Africa. PloS One, 15(12), e0244080. doi:10.1371/journal.pone.0244080.
2. **White, J.A**., Levin, J., & Rispel, L.C. (2020). Migrants' perceptions of health system responsiveness and satisfaction with health workers in a South African Province. Global Health Action, 13(1). doi:10.1080/16549716.2020.1850058.
3. **White, J.A.**, & Rispel, L.C. (2021). Policy exclusion or confusion? Perspectives on universal health coverage for migrants and refugees in South Africa. Health Policy and Planning, czab038, https://doi.org/10.1093/heapol/czab1038.

Under review

4. **White, J. A**., & Rispel, L.C. Contested and nervous spaces: Exploring the environment of health care provision for migrants in the Gauteng province of South Africa. *Anthropology Southern Africa.*

ABSTRACT

Background

The context of this PhD study is the global goal of universal health coverage (UHC) and the dearth of empirical studies on migrants' perceptions of health system responsiveness and their experiences of social exclusion in the health systems of African host countries.

Aim

The overall aim of the study was to examine health system responsiveness and social exclusion among migrants in the public health sector in the Gauteng Province of South Africa. The specific objectives of the study were to:

1. Explore whether legislation, health policies and the perspectives or actions of health policy actors facilitate UHC for migrants, or exacerbate their exclusion.
2. Explore the environment of health care provision to migrants.
3. Determine the experiences of migrants utilising health care services in Gauteng.
4. Determine health care providers' perceptions of delivering health services to migrants in Gauteng.

Methodology

Between 2015 and 2018, a cross-sectional mixed methods study was conducted in 13 public health facilities in the Gauteng Province of South Africa. Drawing on health system responsiveness and social exclusion theories, this PhD study consisted of four components: in-depth interviews with 18 key informants combined with a document analysis; ethnographic observations at 13 public health care facilities; a survey among 251 migrant patients; and a survey among 277 health care providers. STATA® 15 was used for quantitative data analysis, while thematic analysis was used to analyse the qualitative data.

Results

Paradoxically, legislation and health policies in South Africa both facilitate and exclude health care for migrants. The rights-based South African Constitution and the National Health Act are enabling, whereas the Immigration Act and draft 2019 National Health Insurance Bill are

exclusionary. This legislative disjuncture is exacerbated by variations in the content, interpretation and/or implementation of policies at the provincial level.

The ethnographic observations revealed busy, frantic or nervous health care spaces and contestations between patients and health workers, and among health workers. The presence of migrant patients during busy periods served as a detonator for rude or discriminatory remarks, exacerbated by staff shortages and language barriers.

In the migrant patient survey, 94.3% reported that the consulting nurse or doctor listened to them and 89.4% said that they received information about their condition. However, 81.7% did not know the name of the consulting nurse or doctor and 30.0% of patients complained about waiting too long. The mean patients' satisfaction scores with health workers were 7.0 (95% CI 6.42-7.63) for clerks, 7.4 (95% CI 7.1-7.6) for nurses and 8.3 (95% CI 7.93-8.63) for doctors. The predictors of patient satisfaction with nurses included receipt of information about their condition; polite treatment; time spent at the health facility; and receiving prescribed medicines.

In the health care provider survey, 21.0% reported that they had witnessed discrimination against migrants, while 22.6% reported differential treatment of migrant patients. Exclusionary perspectives among health care providers varied by socio-demographic and employment characteristics, including health care provider category and the type of health care facility.

Conclusion

The PhD generated new knowledge on health system responsiveness, social exclusion and the experiences of international migrants in Gauteng public health services. The findings highlight the need for investment in a migrant-sensitive health system as part of South Africa's quest for UHC.

ACKNOWLEDGEMENTS

There are many people I would like to thank who supported and encouraged me during my PhD journey. First and foremost, I sincerely wish to express my gratitude to my supervisor, Professor Laetitia Rispel for her support and commitment during my PhD journey. Her unwavering support during the difficult moments of my journey is a testament to her compassion, empathy and visionary supervision style. I have learnt so much from her about the South African health system, its complexities, contradictions and nuances. She constantly pushed me to look deeper at the data, and encouraged my professional and personal growth in the topic and during the PhD journey. This thesis would not have been possible without her.

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And God is able to make all grace abound toward you, that you, always having all sufficiency in all things, may have an abundance for every good work – II Corinthians 9:8

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ACRONYMS AND ABBREVIATIONS

ASEAN	Association of South East Asian Nations
CHC	Community Health Centre
CSDH	Commission on the Social Determinants of Health
ER	Emergency Room
EU	European Union
GCRO	Gauteng City Region Observatory
GP	Gauteng Province
HIV	Human Immunodeficiency Virus
HSR	Health Systems Responsiveness
HRW	Human Rights Watch
HREC	Human Research Ethics Committee
IOM	International Organization for Migration
KI	Key Informant
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and Pansexual
LMICs	Low and Middle Income Countries
MDGs	Millennium Development Goals
NCRA	National Consortium on Refugee Affairs
NDoH	National Department of Health
NHI	National Health Insurance
NHRD	National Health Research Database
PHC	Primary Health Care
PhD	Doctor of Philosophy
READ	Ready materials, Extract data, Analyse data, Distil findings
REDCap	Research Electronic Data Capture
SAHRC	South African Human Rights Commission
SDGs	Sustainable Development Goals

SEKN	Social Exclusion Knowledge Network
StatsSA	Statistics South Africa
UHC	Universal Health Coverage
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
WHO	World Health Organization

CHAPTER 1: BACKGROUND AND CONTEXT

1.1 Introduction

The International Organization for Migration (IOM) defines a migrant as "any person who is moving or has moved across an international border or within a country away from his/her habitual place of residence, regardless of the person's legal status; whether the movement is voluntary or involuntary; and/or the causes of the movement" (1). As the focus of this PhD study is on international migrants, the ensuing discussion provides the background to and context of international migration.

International migration or movement across national borders, is influenced by a complex set of socio-political and/or economic factors, including the quest for improved economic opportunities, educational studies or advancement, and/or political conditions in the home countries of individuals (1). Prolonged conflicts or wars, major economic and political upheaval and the effects of climate change also contribute to the large-scale cross-border movement and subsequent displacement of people (1, 2). In 2020, the IOM estimated that there were around 281 million people or 3.5% of the world's population who have crossed international borders to live in various host countries (3). Notwithstanding the relative small proportion of the world's population who have moved across borders, the status and classification of international migrants remain contested (4). Although country specific, labels of temporary, permanent, illegal or undocumented, refugees and asylum seekers or highly-skilled and business migrants have implications for integration or inclusion into host countries, access to social services and cultural acceptability (5) .

My PhD focuses on the experiences of international migrants when they utilise public health services in the Gauteng Province of South Africa. Specifically, I am interested in migrants' perspectives on health systems responsiveness (HSR) and their experiences of social exclusion. The World Health Organization (WHO) defines HSR as the ability of a health system to meet the expectations of individuals when they utilise health services (6). HSR focuses on eight domains of dignity, autonomy to participate in health-related decisions, confidentiality,

prompt attention, adequate quality of care or basic amenities, communication, access to social support networks, and choice of healthcare worker (7 ,p.5). The Social Exclusion Knowledge Network (SEKN) defines social exclusion as a relational concept, rather than a "state" as this could attach a label and be discriminatory (8). Social exclusion is "d*ynamic, multi-dimensional processes driven by unequal power relationships that operate along and interact across cultural, economic, political and social dimensions and at different levels* (8).

This PhD thesis brings together three strands at conceptual and methodological levels: firstly, the discourse on migration and international migrants; secondly, the global goal of universal health coverage (UHC) enshrined in the sustainable development goals (SDGs) to "leave no one behind"; and thirdly, the experiences or perspectives of [international] migrants who are the core focus of my thesis. Hence, this chapter aims to summarise the background to, and context of, my PhD research by highlighting each of these inter-dependent and intersecting strands. In the next section of the chapter (1.2), I discuss the global context, followed by the South African context (section 1.3). In section 1.4, I outline the problem statement, followed by the study rationale (1.5). Section 1.6 describes the PhD study aim and objectives. Lastly, section 1.7 outlines the structure of this thesis.

1.2 The global context

Figure 1 provides an overview of selected statistics on international migrants in 2020 (9).

Although there are contestations about the quality and accuracy of statistics, in mid-2020, there were an estimated 281 million international migrants, of whom 9% were in Africa (9). The median age of migrants was 39 years, 15% were under the age of 20 years, and 12% were 65 years and older (9).

The 2030 Agenda for Sustainable Development replaced the Millennium Development Goals (MDGs) (2). Although many countries had made significant progress towards achieving the MDGs by the target date of 2015, social and economic inequalities remained stark, both among and within geographical regions and countries (10).

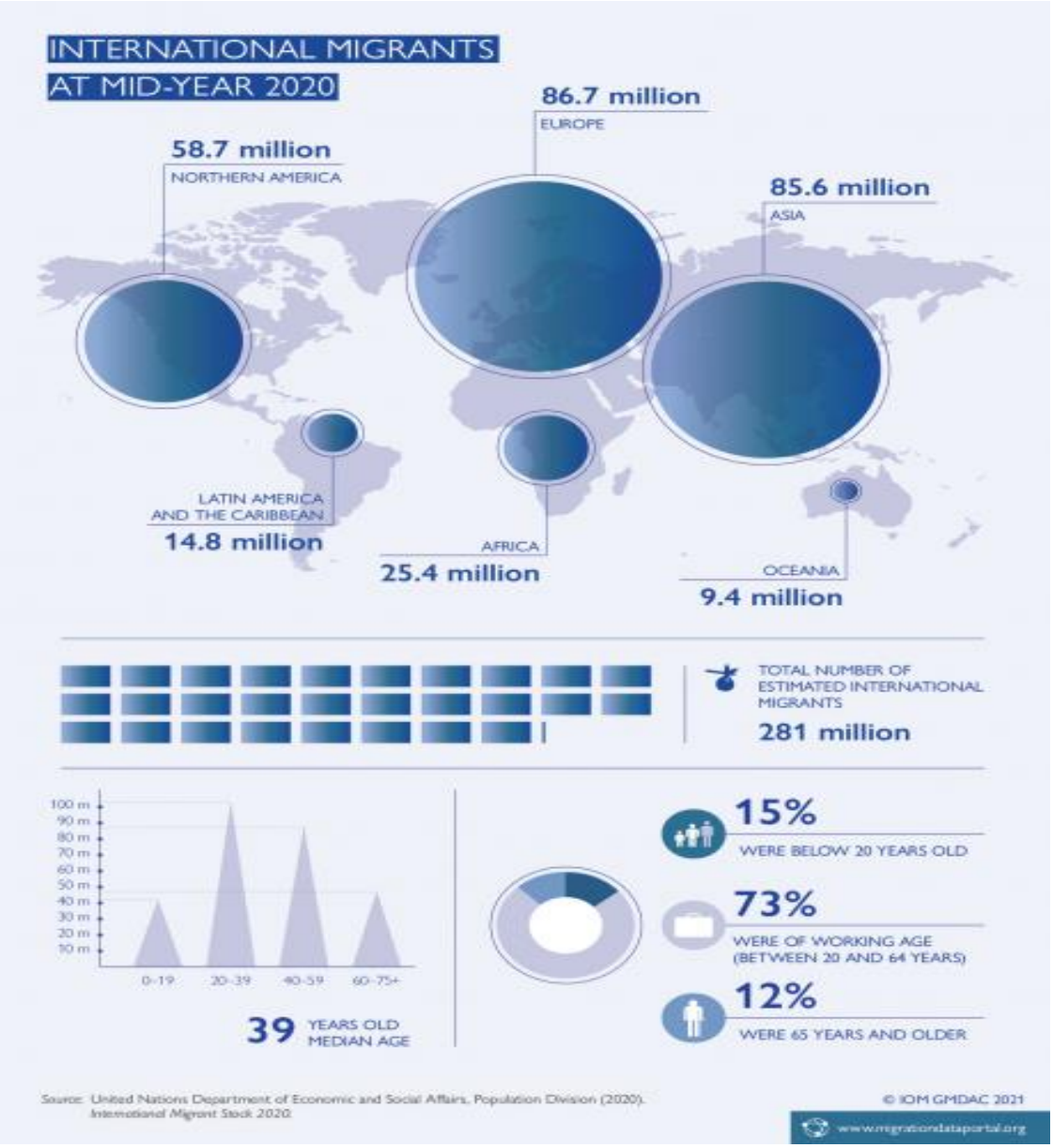


Figure 1: International migrants at mid-year in 2020

Source: https://migrationdataportal.org/; accessed 15 June 2021

The SDGs drew on the successes, failures and implementation lessons of the MDGs (10), and outline a vision of inclusive, sustainable development and people empowerment, underpinned by human rights, gender equality and the lasting protection of our planet and its natural resources (2). Unlike its predecessor, the SDGs are explicit on "the positive contribution of migrants for growth and sustainable development" (2 ,p.7), the multi-dimensionality of international migration and the need for coherent and comprehensive policy responses. The motto of the SDGs to "leave no one behind" emphasises the principles

of inclusivity, respect for human rights and meeting the needs of vulnerable populations such as migrants (2).

However, some researchers have argued that the SDGs are not value-neutral, and that the explicit inclusion of migrants in the 2030 development agenda could have unintended negative consequences (11-13). Carmel and colleagues have underscored the intersection of the politics of post-colonialism and gross unequal economic development and the process of migration and the experiences of migrants (11). They demonstrate how "wider social inequalities of gender, race, class, age or sexuality interact with specific legal statuses of migration", while they argue that "dominant social actors purposefully obscure the power relations… inherent in the governance of migration" (11 ,p.3-4). Suleiman has argued that the framing of the SDGs sustains a problematic understanding of migration, and reproduces structural and political inequalities encountered by migrants (13). Similarly, Weber has argued that the notion to 'leave no one behind' rests on a neo-liberal ideology of development that could undermine grass-roots struggles for "socially just and ecologically sustainable approaches to development"(12,p.399).

Notwithstanding these critiques, other have welcomed the SDGs for the opportunities they create, the explicit focus on migrants and sustainable development (14) and for emphasising the interconnections among development, the environment, poverty and marginalisation (15). The wider set of ambitious health-related goals in the SDGs, including an explicit target on UHC, provide a leverage for health system transformation (16). UHC is defined as all individuals receiving the "full spectrum of essential, quality health services they need without suffering financial hardship" (17). UHC is seen as an important strategy to address health inequities, social exclusion and the right to health (18), while three global reports in 2018 underscored the inter-relatedness of UHC and quality of care (19-21).

UHC is also important to achieving an improved level and distribution of population health (16). However, the relationship between population health and migration is complex. The IOM has documented the social determinants of health (such as working or living conditions)

that influence the health and well-being of migrants during the various phases of migration (1). It is beyond the scope or focus of this chapter to discuss these social determinants of health. Importantly, the factors that shape migrants' health at the phase of their arrival and integration in the host country are migration policies, legal status, access to health services, social exclusion, discrimination and exploitation, cultural values, and language differences (1).

In line with the SDG target on UHC, in 2019, the World Health Assembly reiterated the call to their member states to prioritise the mainstreaming of all categories of migrants into health policies and to strive towards UHC (22). The IOM, as the United Nations Agency on Migration, in turn has emphasised that inclusive UHC requires a combination of evidence-based policies, sustainable financing, intersectoral action and the participation of migrants and health workers in the transformation of health services (23).

The 2020 World Migration Report has emphasised the health-care system as a social determinant of migrants' health, in turn shaped by the policies and legal frameworks of individual countries (1). In some instances, migrants are either fully or partially integrated, or excluded from health care services (23, 24).

Globally, an ambiguous picture emerges on UHC for migrants, illustrated by the findings of the 2020 World Migration Report, summarised in Table 1.

Table 1: Health systems responses to migrants: Summary of global issues

<table>
<tr><th colspan="3">Overall Messages</th></tr>
<tr><td colspan="3">

The health-care system is a determinant of health.
Policies and legal frameworks of individual countries determine migrants' access to adequate, equitable and affordable access to health services.
Varying experienced of discrimination, xenophobia and social exclusion.
Barriers or capacity constraints in local health systems to manage health needs of migrants.
Improved HSR requires development of migrant-sensitive health systems that could consist of:

✓ Access to primary health care.
✓ Inclusion in national disaster preparedness and response plans.
✓ Culturally sensitive and linguistically diverse health service provision.
✓ Ethically reporting mechanisms within routine health information systems to plan for migrant needs.
✓ Appropriate resource allocation.

</td></tr>
<tr><th>Health system issues</th><th></th><th>Issues related to migration or migrants</th></tr>
<tr><td>

Communication challenges --- influence diagnosis and treatment.
Continuity of care:

Migrant understanding of the health-care system.
Case management of migrants and across different parts of the health-care system.

Cultural sensitivity in health care provision.
Health providers expressed challenges of:

Language and cultural barriers.
Resource constraints within their workplaces.
Incoherence between professional ethics and domestic laws that limited migrants' right to health care.

</td><td>⟷</td><td>

Disruptions in health-care delivery in countries of origin.
Challenges with navigating unfamiliar health system.
Difficulties in expressing symptoms and/or understand the treatment instructions due to language barriers.
Vaccination gaps among migrant children from conflict settings.
Migrants' cultural constructs of illness causation, influenced by various social determinants of health.
Perceived trust or lack of trust in the health-care system and/or health care providers.
Patients may resort to using traditional medicine or own community resources for treatment.

</td></tr>
</table>

Source: Adapted from World Migration Report 2020 (1 ,p.219)

1.3 The South African context

1.3.1 History as context

In 2019, the IOM estimated that South Africa was host to 7.2% of international migrants (1). South Africa remains one of the top 20 destination countries in the world, and the most significant destination country in Africa (1). This is because of the country's relative political stability, advanced economy and good infrastructure (1).

However, South Africa has a long, complicated history as a host country to international migrants. With the growth in the mining and agriculture sectors in the late nineteenth century, South Africa relied heavily on cheap labour from migrants predominantly from the Southern Africa region (25) . Crush highlighted that prior to democracy in 1994, the apartheid government's immigration policy was "a naked instrument of racial domination" (26). Apartheid, which sanctioned racism and social stratification based on skin colour, was a crime against humanity (27). Under apartheid, citizenship was reserved for white international migrants, while the same right was not extended to black international migrants (25) . These black migrants came to South Africa as temporary contract workers, giving rise to the notorious migrant labour system (26). This system mandated migrant workers to return to their countries of origin upon completion of their contracts, regardless of the length of stay in South Africa (25). This legacy of discrimination, undignified treatment and denial of the rights of black migrants fundamentally shaped immigration policies and societal attitudes in the post-apartheid period (26).

In 1994, South Africa's first democratic government was elected, which was instrumental in the establishment of the African Union (AU) and the strengthening of the Southern Africa Development Community (SADC) (28). South Africa reclaimed its space as a member of the United Nations (UN) (28). Consequently, the country became a signatory, acceded and/ or ratified several international human rights instruments, affirming a commitment to uphold, protect and fulfil the basic human rights of all people, including migrants and refugees (29, 30). Furthermore, the advent of democracy was accompanied by the adoption of the South Africa Constitution in 1996, which contains the Bill of Rights that provides for redress and guarantees respect and upholding of human rights (28, 31).

1.3.2 Migrant numbers, perceptions and reality

As diplomatic relations with African countries normalised in democratic South Africa, there was an increase in intra-African migration to South Africa (28). Other factors that influenced

increased migration included South Africa's political stability and economic status, as well as the economic decline in many neighbouring countries (32).

The new Immigration Act, which replaced the Aliens Control Act of 1991 (as amended in 1995), was promulgated in 2002, after eight years of negotiations (26). Although the 2002 Act contained a more immigration-friendly framework and commitment to eliminating xenophobia in society (33), Crush pointed out that the Act expected South Africans to spy on immigrants, through its provisions on community policing (26). The reasons for the delays in the finalisation of the Act were the perceived undesirability of migrants and refugees from other African countries and the conceptualisation of immigration policy reform as an issue of control and exclusion (26). In addition, there was intense political conflict and disagreement on immigration policy in democratic South Africa, as a member of an opposition party, rather than the ruling African National Congress, governed the home affairs portfolio (26).

Notwithstanding these contestations, the 2020 Africa migration report confirmed that South Africa is the continent's top migration destination with an estimated 4.2 million immigrants living in South Africa (34). This shows an increase from the 2.2 million reported in the 2011 census (35), and is in line with global trends (1). These numbers must be viewed with caution because of the contestations surrounding precise migrant data, inadequate data collection systems, and allegations of inflated migrant numbers by government to justify stricter immigration controls, or by non- to obtain increased donor funding (36). Additionally, the data may not reflect the accurate number of migrants living in South Africa because undocumented migrants are unlikely to participate in official government surveys (36).

More than two decades since democratic change and its presence as a UN member state, South Africa remains an ambiguous host country (37). Kanayo and colleagues examined push and pull factors of international migration (38). They found that economic factors, political factors and the influence of migrant networks continue to play an important role in South Africa's attraction to African migrants (38). The ambiguity is reflected in South Africa's absorption of migrants with relatively little organised political opposition, unlike the situation in some European countries (39). Simultaneously, the grim statistics between 2006 and 2018 reflect the incidents of xenophobic violence, threats, and killings of foreigners (40).

Between March 2019 and March 2020, Human Rights Watch (HRW) examined xenophobic violence in Gauteng, KwaZulu Natal and the Western Cape (41). They found that citizens use scapegoating tactics to blame migrants for poor service delivery and frame migrants as criminals, while justifying the "collective punishment" of migrants through xenophobic violence (41). During the same period (March 2019 – March 2020), disparaging remarks about migrants were made in the media by individuals in positions of authority. The Minister of Home Affairs, Dr Aaron Motsoaledi (who was also the former Minister of Health), blamed migrants for overburdening the public health system and noted that undocumented migrants are engaged in criminal acts (42). The Premier of Gauteng Province, David Makhura, tweeted about "taking back the city" from migrants, while participating in a police raid in Johannesburg (43). The former Mayor of Johannesburg, Herman Mashaba, blamed migrants for medicine shortages because they could not be sent home and had to be provided with health services. Simultaneously, Mashaba criticised the Minister of Home Affairs for not taking stronger action against undocumented migrants (44). As these statements were made alongside rising tensions within communities, Chenzi has argued that these views may trigger or exacerbate tensions between citizens and migrants (37).

1.3.3 The South African health system and transformation

The South African Constitution guarantees the right of access to health care *for everyone,* regardless of citizenship (31). As a way to redress the health inequities of the apartheid system, the South African government envisioned a united health system described in the 1997 White Paper for the Transformation of the Health System (45). The White Paper enunciated a vision of a "unified national health system capable of capable of delivering quality health care to all our citizens efficiently and in a caring environment" (45). The White Paper also recognised the contribution of migrant workers from neighbouring countries, and South Africa's obligations in the development of occupational health and safety across the Southern Africa region (45).

Notwithstanding substantial health sector reforms since 1994 and improvements in the health status of the population, broader socio-economic inequalities are also reflected in the

South African health system (28). The health system consists of two tiers, i.e. the public health sector, which is under-resourced and serves 84% of the population; and the private health sector, which is accessed through private health insurance, and serves 16% of the population (28). The public healthcare system in South Africa struggles to meet the health needs of the population it serves (46), including those of migrants (47). The reasons are multi-factorial, but include resource constraints, mismanagement and ineptitude, and lack of accountability (48).

In consort with the global goal of UHC, the South African government has proposed the implementation of the National Health Insurance (NHI) system, which is a financing mechanism to ensure financial risk protection (49). The NHI stated principles include UHC, health care access as a right, social solidarity and equity (49). Although the Green Paper on the NHI was silent on health care access for migrants and refugees (50), the White Paper noted the distinctions in coverage and access to health care for refugees, asylum seekers, temporary residents, documented and undocumented foreign nationals, foreign students and tourists (49). Following the White Paper on the NHI, the NHI Bill was released in 2019 (51). The NHI Bill makes reference to "migrants, refugees and asylum seekers, and illegal foreigners" and their access to emergency health care and basic health services (51). However, the NHI Bill does not provide clarity on the health care entitlements for migrants and refugees beyond emergency health care and basic health services (51).

1.3.4 Gauteng Province and migrants

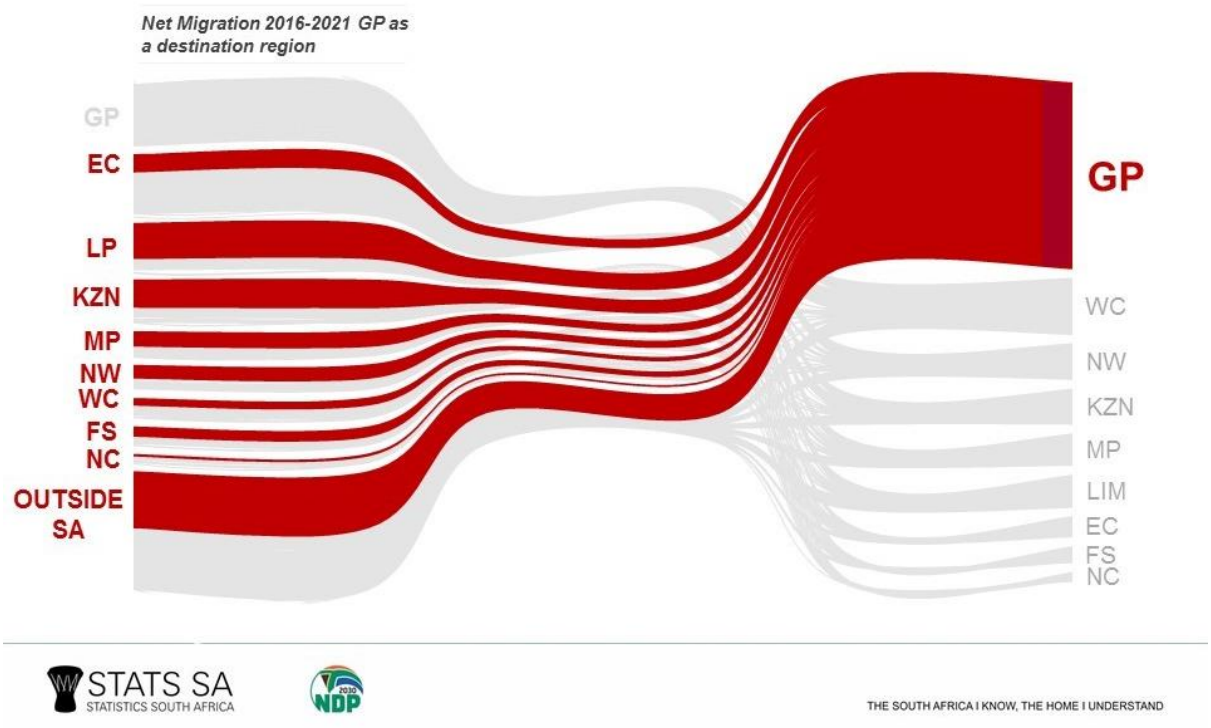
Gauteng Province (GP), one of nine provinces in South Africa, is the smallest in terms of land area. In July 2021, Statistics South Africa confirmed that GP remains the country's most populous province with approximately 15,8 million people or 26,3% of South Africa's population living in this province (52).

In 2017, Gauteng generated 34% of South Africa's gross domestic product, making it the country's biggest provincial economy (53). The province includes the major metropolitan cities of Johannesburg, South Africa's financial capital; and Tshwane, the country's administrative capital (54).

Given its economic strength, Gauteng is host to the largest number of international migrants – estimated at 47.5% of international migrants who live in South Africa (55). GP attracted the most migrants over the period 2016 to 2021 (52) – Figure 2 shows the net migration figures for both international and internal migrants, with GP remaining the preferred destination for international migrants (52).

The Gauteng Department of Health is the largest public sector service provider in South Africa, with a 2018/19 budget of 46.8 billion South African rands, and a staff complement of more than 60 000 people (56).

Figure 2: Net migration 2016-2021 Gauteng as a destination province



Source: http://www.statssa.gov.za/?p=11331; accessed Friday 23 July 2021

1.4 Problem Statement

A central focus of my PhD is the perceptions of, and experiences of migrants on HSR and social exclusion when they utilise public health services. However, existing evidence suggests that migrants' experiences of the public health care services are sub-optimal (57-60). Their

experiences are characterised by communication difficulties and medical xenophobia, made worse by the lack of legal documentation and insufficient policy attention on migrants (61-63). Yet, there is a dearth of empirical studies that combine the lens of HSR and social exclusion to examine migrants' experiences of public health services, especially in an African context. Hence, one of the research questions in this PhD study was to examine the experiences of migrants, specifically their perceptions of HSR and their expressed satisfaction with health care services.

The experiences of migrants cannot be viewed in isolation from the country's laws and policies that enable access to health care within a human rights perspective (24). South Africa has a rights-based constitution, and is signatory to many of the international declarations on human rights (31). However, a conceptual and practical problem is that the draft National Health Insurance (NHI) Bill, the legal framework for the implementation of the NHI system, refers to "illegal foreigners" and is unclear on health care coverage for migrants (51). Consequently, another PhD research question was whether legislation, health policies and the perspectives or actions of health policy actors facilitate UHC for migrants, or exacerbate exclusion.

The health care environment and the intersection with the behaviours and actions of health workers and patients also influence migrants' perceptions of HSR. The mainstream media reports with regularity the problems experienced at public health facilities, and the negative experiences of patients (64-67). Given the PhD focus on migrant patients, another research question centred on the physical, social and cultural environment of care provision is for migrant patients.

The actions of health policy actors such as health care providers also influence migrants' utilisation of health care, and migrants' experiences when they visit health facilities (68). These providers are the personification of the health system (69), and critical to the achievement of UHC (70). The health care providers are bound by professional obligations and codes of ethics and also have to honour the rights enshrined in South Africa's Constitution (31). One of the core problems identified by the Office of Health Standards Compliance (OHSC) are the negative attitudes of health care providers to poor patients (71). Given this

criticality of health care providers, another PhD research question focused on the perceptions of health care providers delivering health services to migrants in public health facilities.

1.5 Study rationale

The SDGs underscore the importance of migrants to sustainable development, but also highlight their vulnerabilities and risk of social exclusion and discrimination (2). South Africa is of strategic importance in the Africa region, with international migrants comprising around 7 percent of the population (1). In addition, South Africa has a rights-based Constitution that only makes a distinction on the basis of citizenship for the elections (31).

Hence, the rationale for my PhD is explained below:

a. There is a dearth of empirical studies that explore the perspectives of international migrants on HSR and their experiences of social exclusion.
b. The generation of new knowledge on:
    i. International migrants' experiences of the domains of HSR, social exclusion and their satisfaction with health workers
    ii. Coherence across South Africa's Constitution, legal frameworks and policies that determine international migrants' access to adequate, equitable and affordable health services.
    iii. The physical, social and cultural environment of health care provision, and its intersection with the behaviours and action of migrants and health workers
    iv. The perspectives of health care providers on social exclusion and HSR for migrants.
c. The study findings could contribute directly to health policy or health system improvements to achieve a migrant-sensitive health system, and indirectly to strategies needed to achieve quality UHC in South Africa.
d. The study findings on the experiences of migrants in the public health sector of South Africa can provide important lessons for other low-and middle-income countries (LMICs) as they strive towards achieving UHC, that is true to the motto of "leave no-one behind" (2).

1.6 Study aim and objectives

The overall aim of the study was to examine HSR and social exclusion among migrants in the public health sector in the Gauteng Province of South Africa. The specific objectives of the study were to:

1. Explore whether legislation, health policies and the perspectives or actions of health policy actors facilitate UHC for migrants, or exacerbate exclusion, and reproduce inequalities and discrimination against migrants.
2. Explore the environment in which care is delivered to migrants, specifically:
    a. The physical, social and cultural environment of health care provision at health facilities.
    b. The behaviours and practices of health workers and patients (especially migrant patients), i.e. the culture in each health facility.
    c. The intersection between culture and the environment, and how it affects health care provision to patients, particularly migrant patients.
3. Determine the experiences of migrants utilising health care services in Gauteng public health facilities, specifically:
    a. Their socio-demographic characteristics.
    b. Their perceptions of the responsiveness of the health care system to their health care needs.
    c. Their satisfaction with health workers.
    d. The association between their perceptions of HSR and their satisfaction with health workers.
4. Determine health care providers' perceptions of delivering health services to migrants in Gauteng public health facilities:
    a. Their socio-demographic and occupational characteristics.
    b. Their perspectives on discrimination, social exclusionary views or practices, and the inclusion of migrants and refugees in the NHI.
    c. The relationship between the perspectives of health care providers and their socio-demographic and occupational characteristics.

1.7 Structure of the thesis

In **Chapter 1** of this thesis, I have provided the background to and context of this PhD study, the global and South African context, concluding with the study aim and objectives.

In **Chapter 2,** I have described the operational definitions used in the thesis and provided a critical review of the literature on HSR, social exclusion and international migrants.

Chapter 3 is an integrated description of the PhD methodology, including the ethical considerations of researching international migrants in the public health sector of Gauteng.

Chapters 4 to 7 contain the PhD study findings, presented as individual papers:

- **Chapter 4**: Policy exclusion or confusion? Perspectives on universal health coverage for migrants and refugees in South Africa *(Published in Health Policy and Planning)*.
- **Chapter 5**: Contested and nervous spaces: Exploring the environment of health care provision for migrants in Gauteng Province *(In preparation for submission to Globalization & Health).*
- **Chapter 6:** Migrants' perceptions of health systems responsiveness and satisfaction with health workers in a South African Province *(Published in Global Health Action).*
- **Chapter 7:** Social exclusion and the perspectives of health care providers on migrants in Gauteng public health facilities, South Africa *(Published in PLoS ONE).*

In the final **Chapter 8**, I have presented an integrated and critical discussion of all the elements of the PhD thesis. This chapter also contains the policy implications of the study and the scholarly contribution of my PhD. The chapter concludes with recommendations for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In line with the study objectives, this chapter contains a brief review of the relevant literature on migrants, universal health coverage (UHC), health service utilisation and health systems responsiveness (HSR). Section 2.2 presents the definitions of terms used in the thesis, followed by a synopsis of the literature on legislation, health policies and health care for migrants (Section 2.3). In Section 2.4, selected studies on the environment of health care provision, migrants' experiences of health care utilisation (including HSR), are summarised, while Section 2.5 deals with research on health care providers' perceptions on migrants, health care and UHC. Although these sections overlap, each is presented separately for the sake of clarity. Further details on the literature reviewed for each study objective are contained in Chapters 4-7.

2.2 Definition of terms

Asylum seekers	An asylum-seeker is an individual whose claim for international protection has not yet been finalised by their host country (72). In this study, an asylum seeker is an international migrant.
Environment	The environment refers to the physical, social and cultural aspects of health care provision (73).
Health systems responsiveness	Health systems responsiveness is an indicator of the performance of the health system (6) and refers to people's experiences of dignified treatment, autonomy, confidentiality, prompt attention, access to networks, quality of amenities, choice of provider, and trust (74 ,p.8). In this PhD study, I focused on the domains of prompt attention, communication, confidentiality, dignity, and quality.

Health care provider/ Health worker	Health worker refers to any staff member who contributes to health care provision, whether directly (such as nurses or doctors), or indirectly (such as clerks, cleaners, security personnel) (75). The term **health care provider** is used when the person is a trained health professional such as a nurse or doctor.
Medical xenophobia	Medical xenophobia is defined as **"**negative attitudes and practices of health professionals and employees towards migrants and refugees based purely on their identity as non-South African" (61 , p.655).
Migrant	In this PhD study, a migrant is a person who has moved across an *international* border away from his/her habitual place of residence, regardless of his/her legal status, causes of the movement, or whether it was voluntary or involuntary (76). Refugees, asylum seekers, immigrants, and un/documented migrants are included in this broad category of migrant.
Refugee	A refugee is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (77).
Social exclusion	Social exclusion is defined as the "dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions-economic, political, social and cultural-and at different levels including individual, household, group, community, country and global levels" (78 ,p.36). In this PhD study, the four dimensions were adapted: the social dimension refers to relationships and views of social solidarity and support expressed for the inclusion of

	migrants and refugees in South Africa's NHI system. The economic dimension considers issues such as access to income and livelihoods that influence migrants' access to the NHI. The cultural dimension focuses on the perspectives of policy actors on the acceptance and respect of diverse values and ways of living, including extreme views of stigma and discrimination. The political dimension includes the formal rights embedded in legislation, policies and practices and the conditions in which rights are exercised, e.g. access to health care.
Universal health coverage	Universal health coverage is defined as all people receiving the quality health services they need, while ensuring that health service utilisation does not expose users to financial hardship (79 ,p.7).
Utilisation of health care services	Utilisation of health care services refers to "…the actual uptake of health services" (80 ,p.1070), also known as realised access (81).

2.3 Migrants, legislation, health policies and policy actors

The first objective of this PhD was to explore whether [health] legislation, health policies and/or the perspectives or actions of health policy actors facilitate UHC for, or exacerbate exclusion of, migrants. This is because laws and policies are structural determinants of health care access and health service provision for migrants (1). Similarly, the perspectives of health policy actors are important, as they are individuals or groups who influence or shape UHC for migrants, whether directly or indirectly, formally or informally, by virtue of their position, knowledge, and/or experience (82) . The scholarly value of reviewing relevant legislation and health policies that affect UHC for migrants, or of exploring the perspectives of key health policy actors, is to contextualise the experiences of international migrants in the public health care system of Gauteng.

The starting point for research studies on migrants, legislation, health policies and health care is the 1948 Universal Declaration of Human Rights (UDHR), adopted by the United Nations (UN) General Assembly (83). The 30 articles in the Declaration specify individual basic rights and “fundamental freedoms", and commits all its member states to recognise the "equal dignity and rights" of all people, regardless of "nationality, place of residence, gender, national or ethnic origin, colour, religion, language, or any other status" (83 ,p.6). The UDHR informed subsequent international human rights legislation, the International Bill of Human Rights (84) and various Conventions and Protocols that govern the humane treatment of international migrants in general, and refugees and asylum seekers in particular (85-87). Article 25 of UDHR notes that “***everyone*** *has the right to a standard of living adequate for health and well-being, including….****medical care*** *and necessary social services*” (88 ,p.52). Several international agreements such as the 2016 New York Declaration for Refugees and Migrants (UNGA) and the World Health Assembly resolution on Promoting the Health of Refugees and Migrants (WHA 70.15), stipulate the protection of migrants, especially of refugees and asylum seekers, and their access to essential health services (89, 90).

As shown in Chapter 1, Agenda 2030 for Sustainable Development reiterates the obligations of UN member states to respect the human rights and needs of all people, especially of vulnerable populations such as migrants, with UHC, a specific target to achieve (91). Several authors have examined the intersection of legislation, health policies and health care access or UHC for migrants, summarised in Table 2.

Table 2: Summary of studies on migrants, legislation, health policies and health care

Country	Legislative provisions	Health care access/ UHC
High-income countries in Europe, United Kingdom or America		
Germany (92).	• Health insurance is compulsory (Sozialgesetzbuch §5). • Restrictions at a federal state level for asylum seekers • Migrants in Germany have the right to access the regular health care system after 15 months of stay. • Immigration law in Germany requires public institutions (excluding medical) to report migrants without a valid residence permit to immigration authorities. • Migrants without a residence permit risk being deported when seeking medical care if they are not able to pay for it.	• Asylum seekers and undocumented migrants have access to care for acute and certain obstetric conditions. • Asylum seekers must obtain medical treatment voucher each time they seek medical care. • Asylum seekers and undocumented migrants are excluded from accessing certain preventive services. • Free medical care services outside of the regular system are mainly available in bigger cities.
Spain (93, 94).	• Strict austerity measures in the wake of the financial and economic crisis in 2008. • Royal Decree Law (RDL) in 2012 reformed public health care • Immigration status determines access to health care. • Legislative restrictions at Federal level.	• RDL has severely impacted access to health care for undocumented migrants. • Exclusion of undocumented migrants from basic health care coverage. • Conditional health care services including emergency care, maternal care, children under 18, asylum seekers and victims of human trafficking.
France (95, 96).	• No legal restrictions in theory. • Documented migrants receive care under the common French law system. • Undocumented migrants receive care under State Medical Assistance.	• Reported structural, administrative and financial barriers for undocumented migrants.
United Kingdom (97).	• Restrictive and exclusionary immigration and health policies, especially for undocumented migrants. • Immigration law requires landlords, certain NHS staff to check the status of tenants and patients. • Foreigners categorised as overseas visitors charged full cost of any NHS hospital treatment. • Public institutions, including health, and some of the employees within these	• All migrants have access to primary and emergency care; including the diagnosis and treatment of communicable diseases. • Undocumented migrants are charged for services. • Treatment at hospitals may incur a charge. • Discrepancy between obtaining NHS card (which anyone is entitled to pending registration with a GP) and access to secondary care. • Contradictory processes hinder access to health a services for migrants.

Country	Legislative provisions	Health care access/ UHC
	institutions perpetuate the exclusion of migrants.	
United States of America (USA) (98, 99).	• Restrictive and exclusionary immigration and health policies at federal level, especially for undocumented migrants. • Notion of "Sanctuary cities" that offer some form of protection to undocumented migrants (1).	• Moral and public health crises. • Families separated from each other and detained in holding facilities. • Intimidation within health care settings. • Immigrants more likely to be uninsured; immigrant children twice as likely to be uninsured. • Immigrants have less access to public insurance. • Health paradox – immigrants have better health outcomes.
Low-and middle-income countries		
Indonesia, Malaysia, Philippines, Singapore and Thailand i.e. Association of South East Asian Nations (ASEAN) countries (100) (101), (102).	• Poorly coordinated and restrictive migration policies across ASEAN countries.	• Less comprehensive benefits for migrants compared to citizens (Thailand). • Difficulties in the implementation of UHC systems. • Insufficient integration of all categories of migrants. • Migrants experience various barriers to health care.
Tunisia (103, 104 ,p.184). .	• Lack of migrant-inclusive legislative frameworks.	• Socio-political situation displaced intention of migrant-inclusive health system. • Lack of official documentation exacerbates migrants' vulnerabilities. • Non-responsive health care providers. • Xenophobia and racist attitudes of health care providers.
South Africa (28, 47, 105-108) .	• Rights' based Constitution. • Restrictive immigration laws. • Progressive National Health Act. • Restrictive National Health Insurance (NHI) Bill.	• Reported challenges on health care access for migrants. • Disconnect between the Constitution, immigration and health laws. • Potential conflict between the NHI Bill and the right to health espoused in Constitution. • Reports of medical xenophobia at the hands of some hospital administrators and health care providers.

Notwithstanding the agreement of UN member states on the global goal of UHC, Table 2 shows that there are wide variations in legislation and/or health policies on UHC for migrants, ranging from comprehensive coverage in the minority of countries, to restrictions, especially for undocumented migrants (28, 47, 92-108).

Importantly the majority of reviews or research on legislation and health policies have been conducted in high-income countries (28, 47, 92-108). Although these countries are the hosts to the majority of international migrants (1), there remains a dearth of studies in LMICs that combine a review of legislation and health policies with the perspectives of key health policy actors on international migrants and UHC. In addition, some scholars have highlighted the concept of the "receiving country bias", reflecting the bias of migration research focusing on northern destination countries as its starting point, neglecting the perspectives of origin countries, and of migrants (1).

Abbas et al. (2018) have underscored the importance and need for research that explores the intersection of laws, health policies and UHC for migrants, and the mediating roles of various stakeholders (109). This PhD study was one of the first studies to explore key policy actors' perspectives on migrants, and how these intersect with existing legislation and health policies on migrants in South Africa, thus beginning to address some of the research gaps.

2.4 Experiences of migrants and the health care environment

The experiences of migrants upon utilising health services and the physical, social and cultural environment of health care provision are linked inextricably (73, 110). Hence, the second and third inter-dependent objectives of this PhD were to examine the environment of health care provision, and the health service utilisation experiences of migrants respectively. A scholarly focus on these aspects can generate new knowledge on specific issues to address to enable migrants in Gauteng Province to access essential health services, thereby making progress towards the global target of UHC (2).

A 2019 review of qualitative studies on migrants' experiences of health care in host countries identified five contextual factors or themes: socio-demographic characteristics (e.g. legal status, gender, age, religion); the health care systems of host countries; comparisons with health care in the home country; the interaction between migrant and health care professional during the health care encounter; and migrants' acceptance of the host country (111). Moreover, the interactions between migrants and health care providers are influenced

by the latter's attitudes, prejudices or perceptions of "the other"; language barriers; and cultural awareness or sensitivity (111). Although the review provides useful insights, the conclusions are based on the findings of secondary qualitative studies, the majority of which were conducted in high-income countries.

Several studies across diverse country settings have highlighted the sub-optimal experiences of migrants when they utilise health services (111-115). Linked intricately to migrants' perceptions of health care utilisation are the non-clinical aspects of care, referred to as HSR (see Chapter 1). HSR as a concept has gained traction through the World Health Surveys of the WHO that have used specific indicators for its measurement across geographical settings (6). Some studies have demonstrated that the non-clinical aspects of care, notably the physical environment, communication, and the encounters or interactions between migrant-patients and health care providers, are closely linked with migrant patient satisfaction of health care services (112, 116, 117). A 2010 review on migrant patients' satisfaction with health care services found that negative or low satisfaction scores were associated with the non-clinical aspects of care, including poor communication, lack of information, and disrespectful interactions with health care providers (116).

Research studies in many countries in the European Union (EU) have underscored the poor quality of health care provided to undocumented migrants (115); Roma people and other ethnic minority groups (118, 119). A Swedish study among HIV-positive migrants' experiences of the health care system found that participants expressed appreciation for the free antiretroviral therapy, but complained about the discrimination experienced outside the infectious diseases clinics (113). In England, Eastern European migrants expressed distrust of, and dissatisfaction and frustration with their general practitioners in a 2017 study that explored their health care experiences in their host country (114).

In Germany, a 2012 study found that migrants' satisfaction with health care services was low and determined by the non-clinical aspects of care such as "trust in doctors, friendliness of the doctor, severity of the child's disease, and number of medications prescribed" (112). A 2018 study in Germany highlighted that both migrants and citizens expressed satisfaction with the medical consultation, the treatment they received and their stay in hospital.

However, migrants patients were less satisfied with their participation in decision making and health care providers' responsiveness to their questions (117).

Studies in Africa have found that migrants experienced numerous barriers to health care utilisation (120-122). A 2014 study in Kenya found that migrants, refugees and citizens had similar barriers to health care such as long waiting times, but migrants and refugees also experienced fears of harassment from police, language and financial barriers, as well as discrimination from health care providers (121). Similarly, a study in Botswana found that Zimbabwean migrants experienced medical staff negative attitudes, an inability to choose their medical practitioner, language and financial barriers, exacerbated by the fear of police or immigration officials when utilising health care services (120). Eritrean refugees living in refugee camps in Ethiopia shared their concerns about the insufficient health care facilities and the lack of access to basic health care services in the camps (122). However, there is a dearth of research on migrants' perceptions of HSR, and the intersection with the health care environment.

In South Africa, several studies have explored migrants and refugees' experiences of health service utilisation. The utilisation barriers and challenges include: lack of documentation leading to the denial of care (61, 107, 123); discrimination and medical xenophobia (59, 61); verbal abuse from health care providers (124); delays in receiving care (124); and language barriers (63, 125). Although these studies provided important insights into health care utilisation among migrants in South Africa, all studies were specific to the cities of Cape Town (63), Johannesburg (124, 125), Durban (59) and Giyani (123) in South Africa; and were limited by their focus on migrants from Mozambique (125) and Zimbabwe (59, 61, 123).

Although research studies in South Africa have focused on the relationship between HSR or its domains and patient satisfaction (126-128), there is a dearth of studies on migrants' perceptions of HSR. Khan and colleagues echoed this research gap in a global review on HSR, and underlined the need for evidence on HSR and vulnerable populations, especially in LMICs (129).

This PhD study begins to address the research gaps in three ways. Firstly, the PhD quantified the perceptions of migrants on HSR, their satisfaction with health workers at public health

care facilities in Gauteng Province, South Africa, and the relationship between HSR perspectives and health worker satisfaction. Secondly, the PhD obtained the narratives of migrants on their experiences of utilising health services, and linked these to the HSR survey. Thirdly, the PhD explored the environment of health care provision, and its intersection with both the experiences of migrants, and the perspectives of health care providers (see below).

2.5 Health care providers and their perspectives on migrants

The fourth and final objective of this PhD study was to determine health care providers' perceptions on delivering health services to migrants in Gauteng public health facilities. Health care providers are the embodiment of the health system and thus, are critical to the achievement of UHC (130). Hence, their attitudes, behaviours or practices could either advance or constrain the achievement of UHC for vulnerable individuals, such as migrants (68).

Three systematic reviews have focused on the perceptions and/or experiences of health care providers' and the provision of health care to migrants, asylum seekers and refugees (131-133).

In a 2015 systematic review, which included two studies from Costa Rica and Morocco, health care providers highlighted language and cultural differences, limited institutional capacity, and the contradiction between professional ethics and immigration laws that limited migrants' right to health care (131)

In the 2017 review, health care professionals in PHC settings underscored the influence of political decisions and resourcing priorities on frontline clinical practice, as well as migrants' access to care. They also reported that cultural differences and insufficient knowledge on the health conditions of migrant affected care provision. These challenges were exacerbated by lack of training, insufficient time or professional support to deal with complex health conditions, referral difficulties, increased costs and staff shortages (133).

In the 2019 review, health care providers reported three broad challenges of communication (language), continuity of care (information, education, access to health care) and confidence (trust and autonomy) in health care delivery to migrants and refugees (132). Hence, these perspectives of health care providers mirror those of migrants, and highlight the influence of non-clinical aspects of care and health system challenges on the provision of health care. None of the systematic reviews found evidence of discrimination, xenophobia and other exclusionary practices and perceptions in the delivery of care to migrants. This could be because these issues were not explored or measured in the studies included in the reviews, translating into a gap in the existing literature.

Although many low and middle-income countries are hosts to migrants, there is a dearth of research on health care providers' perspectives on health care delivery to migrants. A 2009 study in Botswana among health care providers reported on the unmet reproductive health needs of immigrants and refugees, and financial and policy barriers to care provision (134). However, the study is dated and did not focus specifically on HSR and social exclusion.

Studies in South Africa have documented the exclusionary practices among health care professionals towards migrants, including discrimination, xenophobic attitudes, and medical xenophobia (59, 61, 68). These studies were small and qualitative in design. Importantly, none of these studies elicited the views of health care providers directly, but reported on the perspective of migrants and refugees utilising health care services. In recognition of the emphasis on migrants' experiences, Vanyoro (135) explored the perceptions of health care providers and demonstrated a counter-narrative to the dominant medical xenophobia sentiment. The study provided valuable insights on the complexities of the range of experiences of health care delivery to migrants in public health care settings. However, this was a small, qualitative study conducted at one clinic within a sub-district in Limpopo Province. Thus, there has been insufficient attention given to measuring the perspectives of health care providers on delivering health services to migrants in South Africa. This PhD study aimed to address this gap in knowledge, by drawing on the social exclusion conceptual

framework of the SEKN (78), to examine the perspectives of health care providers on health care delivery to migrants.

The key messages from the literature review are summarised in Table 3.

Table 3: Summary of the key messages from the literature review

- Majority of studies have been conducted in high-income countries, reflecting receiving country bias.
- Studies in high-income studies found:
    - Variations in legislation and health policies that influence access to health care for migrants.
    - Various barriers to migrants' utilisation of health services, including medical xenophobia.
    - Reported low levels of HSR and/or patient satisfaction.
    - Few studies focus on the perspectives of health care providers.
- Research gaps:
    - Perspectives and experiences of migrants in African host countries
        - ✓ Within the context of UHC.
        - ✓ Using theoretical lens of HSR and/or social exclusion.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter summarises the methodology to meet the four objectives of the PhD (Chapter 1). The chapter begins with a brief description of the PhD conceptual framework (Section 3.2), followed by an overview of the study setting (Section 3.3). The mixed methods study design enabled the optimisation of the strengths of both quantitative and qualitative methods and is shown in Section 3.4.

Section 3.5 summarises the qualitative component of the PhD, specifically the key informant interviews, the document review, the ethnographic research on the health care environment, and a description of quality assurance, reliability and validity.

Section 3.6 summarises the quantitative component of the PhD, specifically the surveys among migrant patients and health care providers respectively. The concluding sections of the chapter contain a description on the integration of the qualitative and quantitative findings (Section 3.7), the ethics of and ethical considerations in this PhD study (Section 3.8) and the potential biases and limitations and how these were addressed in the study (Section 3.10).

3.2 Conceptual framework

The adapted conceptual framework for this PhD study (Figure 3.1) draws on the WHO's health systems strengthening framework (136), Mirzoev and Kane's Health Systems Responsiveness (HSR) framework (74), and the Social Exclusion Knowledge Network (SEKN)'s model of social exclusion (8).

3.2.1 Brief overview of the frameworks

The WHO Framework defines six health system building blocks, namely: leadership and governance; service delivery; human resources (health workforce); finances; medical products, vaccines and technology; and information (136). Notwithstanding the critique and limitations of the WHO framework, these building blocks are universal and useful in highlighting the essential elements needed to improve the performance of a health system (136). The WHO Framework is relevant for my PhD because the research foregrounds the

experiences of international migrants upon utilisation of the health care system in the host country, in this case South Africa.

Closely linked to the WHO building blocks of a health system, is the notion of HSR. The latter is an indication of how well the health system meets the legitimate expectations of the population (6). HSR includes seven domains of dignity, confidentiality, autonomy, prompt attention, access to social support/ networks, availability of basic amenities, and choice of provider (137). In 2017, Mirzoev and Kane expanded the WHO framework, proposing that HSR involves an individual's actual experience with the health care system (i.e. utilisation), which endorses or refutes their initial expectations (74). They proposed a HSR conceptual framework which centres on people's experiences, yet recognising that HSR is influenced by the health system building blocks (e.g. health workforce), and people's prior experiences of utilisation. They also added trust as an additional HSR domain (74). Although it is difficult to measure social networks, trust and choice of provider, Mirzoev and Kane's Framework is relevant for my PhD because migrants' perceptions and experiences of HSR are a key focus area of the study.

Mirzoev and Kane (2017) pointed out that people's experiences or perceptions of HSR occur within historical, political, cultural, social, and economic contexts, in turn influenced by various health policy actors such as health policy makers, managers, health workers, families and civil society (74). These contextual and relationship influences resonate with the social exclusion model, developed by the SEKN as part of the Commission on the Social Determinants of Health (CSDH) (8). In contrast to the commonly used definition of social exclusion as a *state* experienced by particular groups of people, such as migrants, the SEKN adopted a relational approach to social exclusion (8).

From this relational perspective, social exclusion is defined as:

> *"A dynamic, multi-dimensional process driven by unequal power relationships, which operate along and interact across economic, political, social and cultural dimensions- and at different levels including individual, household, group, community, country and global regional levels. These exclusionary processes create a continuum of inclusion/exclusion characterised by an unjust distribution of resources and unequal access to the capabilities and rights required to: create conditions necessary for entire populations to meet and go beyond basic needs; enable participatory and cohesive*

social systems; value diversity; guarantee peace and human rights; and sustain environmental systems" (8 ,p. 36).

The SEKN model has limitations as it was developed primarily as a contribution to the CSDH work to recommend practical action to address the unacceptable health inequities and the social determinants of health (8). Nonetheless, the SEKN social exclusion model is relevant for my PhD as it underscores the importance of the health care as a social system, the role of health policy actors (including migrants), power relationships, and the intersection of all of these with the economic, political, social and cultural dimensions and/or context (8).

3.2.2 Description of my conceptual framework

Figure 2 shows the adapted conceptual framework for my PhD that guided the study, specifically the design of the data collection instruments, the analysis and the interpretation of the findings. The left side of the conceptual framework illustrates that the six building blocks, as proposed by WHO, are essential to the provision of health services and for a well-functioning health care system, utilised by migrants (138).

In my conceptual framework, I hypothesise that there is a dual, yet complex relationship between the health system building blocks and the utilisation of health care system by migrants. A well-functioning health system is more likely to enhance the HSR of migrants. On the other hand, staff shortages or infrastructure difficulties are more likely to hamper health care access and increase migrants' experiences of social exclusion, including overt discrimination.

The utilisation of health service by migrants is also influenced by their socio-demographic characteristics (e.g. gender, or health condition), and the process of migration, which is a social determinant of health (24, 47, 139). A migrant's experience of the six HSR domains are core to the Mirzoev and Kane conceptual framework (74). As indicated, the domain of social networks and the domain of trust (added by Mirzoev and Kane) are difficult to measure. The four dimensions of social exclusion influence the utilisation of health services by migrants. Similarly, the various health policy actors (including migrants themselves) as well as processes, relationships and power also influence their utilisation of health services.

On the extreme right of my conceptual frameworks are the anticipated outcomes of a migrant-sensitive health care system and universal health coverage (UHC), while the impact is characterised by healthy migrants, equity in the level and distribution of health outcomes, and social and financial risk protection (140). These outcomes and impact are mediated by the intersectionality of the six health system building blocks, migrants' experiences of HSR, and the four dimensions of social exclusion.

Table 4 shows the alignment of the study objectives to the PhD conceptual framework.

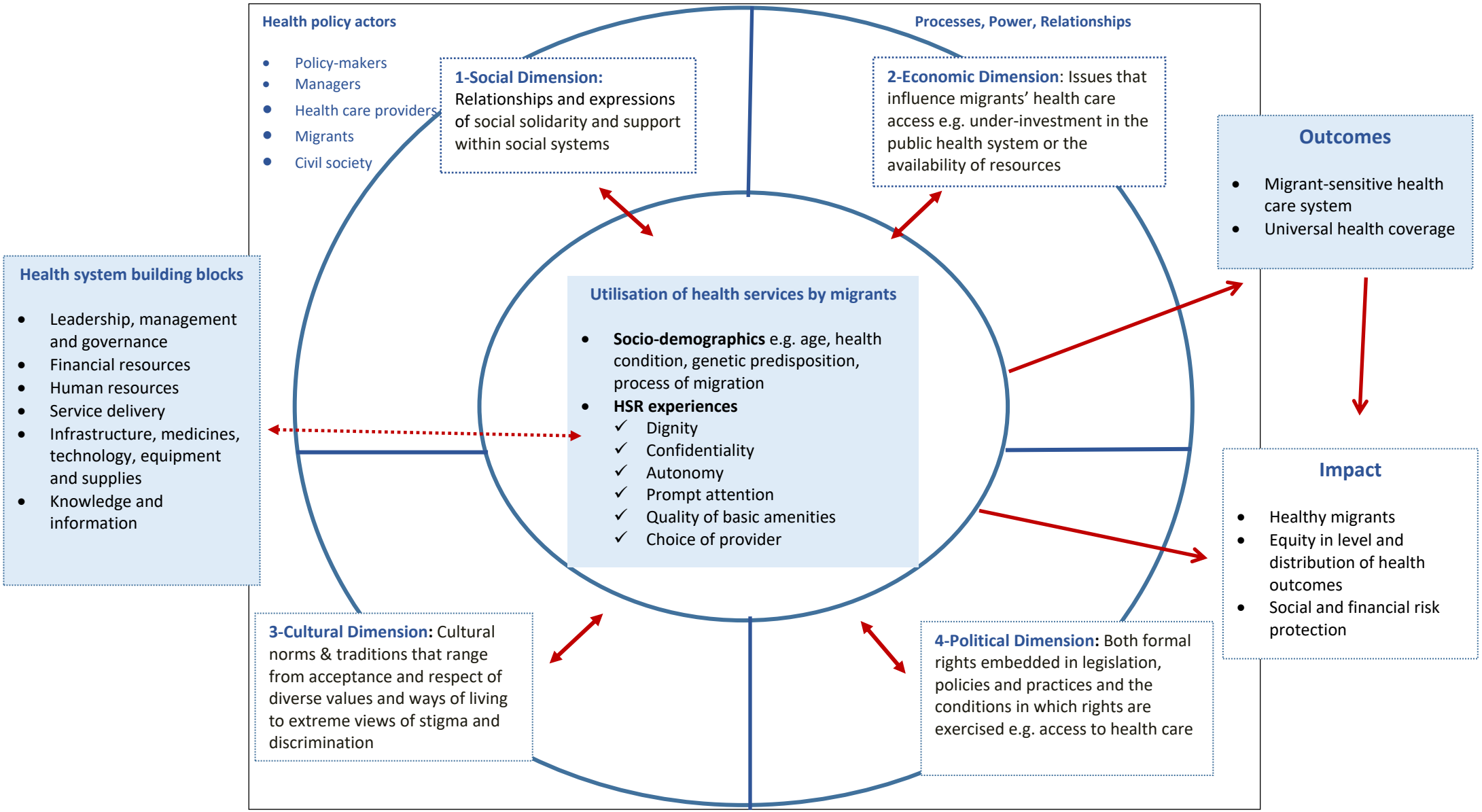


Figure 3: Conceptual framework for PhD study

Adapted from: Health systems strengthening framework (WHO 2007); Mirzoev and Kane (2017) and Social Exclusion Model (Popay et al, 2008)

Table 4: Alignment of objectives, conceptual framework, methods, data collection and research outputs

Study Objective	Elements of conceptual framework	Methods	Data collection	Research outputs
1. Explore whether legislation, health policies and the perspectives or actions of health policy actors facilitate UHC for migrants, or exacerbate exclusion, and reproduce inequalities and discrimination against migrants.	SEKN model	In-depth interviews with key informants (KIs) Document review of relevant legislation and policy documents	Interviews with 18 key informants Review of 24 legislation and policy document	Policy exclusion or confusion? Perspectives on universal health coverage for migrants and refugees in South Africa Paper published by *Health Policy and Planning* **Chapter 4**
2. Explore the environment in which care is delivered to migrants.	HSR framework of Mirzoev and Kane SEKN model Building blocks of health system	Ethnographic observations	Observation guide checklist and observation field notes on 39 field work days	Contested and nervous spaces: Exploring the environment of health care provision for migrants in Gauteng Province Draft paper for submission **Chapter 5**
3. Determine the experiences of migrants utilising health care services in Gauteng public health facilities.	HSR framework of Mirzoev and Kane SEKN model	Survey among migrant patients at 13 selected health facilities	Researcher administered survey among 251 migrant patients	Migrants' perceptions of health systems responsiveness and satisfaction with health workers in a South African province Paper published by *Global Health Action* **Chapter 6**
4. Determine health care providers' perceptions of delivering health services to migrants in public health facilities in the Gauteng Province of South Africa.	SEKN model	Self-administered survey (SAQ)	SAQ survey of 277 health care providers	Social exclusion and the perspectives of health care providers on migrants in Gauteng public health facilities, South Africa Paper published by *PLOS One* **Chapter 7**

3.3 Study setting

The study was conducted at public health facilities in the Gauteng Province of South Africa (Figure 3). Given both Gauteng's strategic importance (Chapter 1) and as a host to a sizable number of international migrants (55), Gauteng public health facilities were the ideal study setting for the purpose of this PhD study that focused on international migrants, health care utilisation, HSR, and social exclusion. The other factors that influenced the selection of Gauteng were geographic proximity to the research team, established relationships with health care authorities; the ability to recruit members of the study population; and budget and logistical considerations.

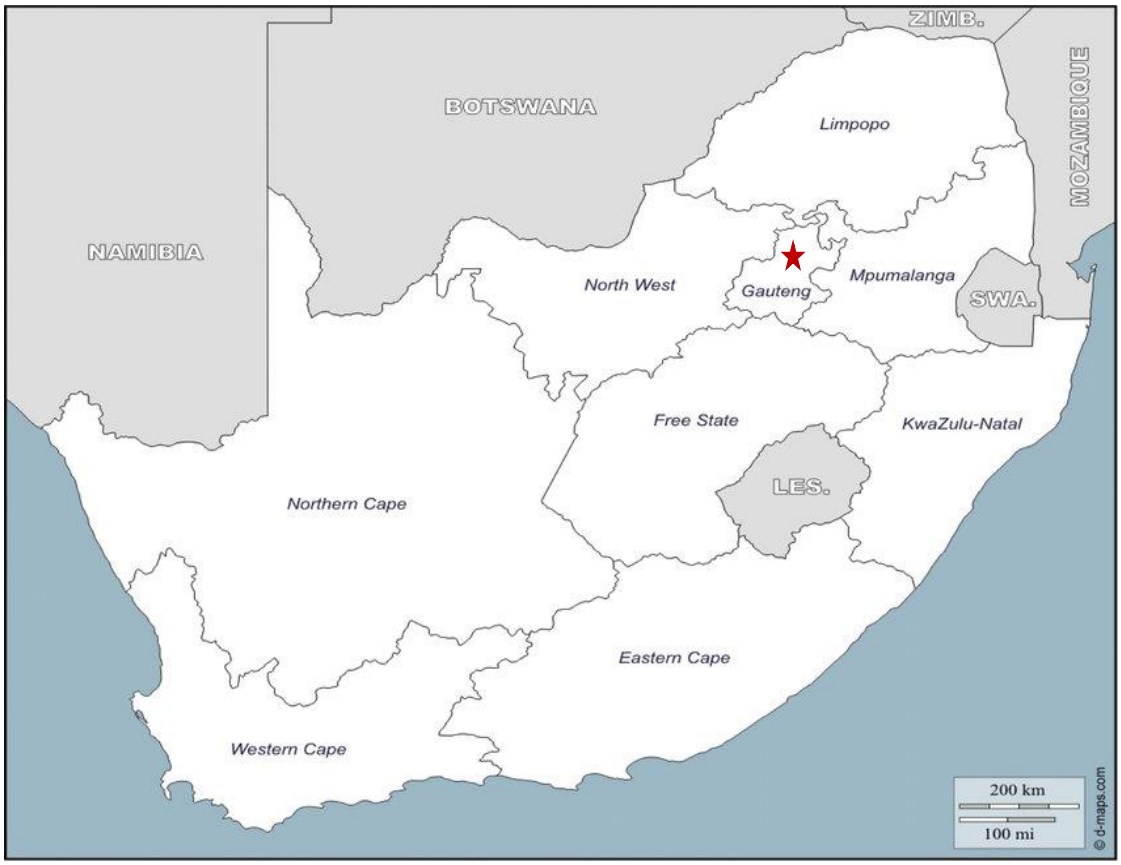


Figure 4: Map of South Africa with star showing the PhD study setting

Source: http://www.southafrica-canada.ca/south-africas-nine-provinces/ accessed 1 April 2021

At the time of the PhD study conceptualisation, there were 354 public health facilities in Gauteng of different types, shown in Table 5. The selection of the study facilities is described in Chapters 6 and 7 (141, 142).

Table 5: Breakdown in numbers by type of facility, Gauteng Province

Type of facility	Number
Central hospitals	4
Community health centres	30
District hospitals	11
Primary health care clinics	290
Psychiatric & tuberculosis hospitals	6
Regional hospitals	9
Regional tertiary hospitals or specialised mother and child hospital	4
Total	**354**

Source: Gauteng Department of Health, n.d.

3.4 Study design

This was a cross-sectional study, using mixed methods. Research using mixed methods is underpinned by the pragmatic rationale, which emphasises the actions and consequences of relationships in the social world, and encompasses the individual's (migrant) interaction with their environment (143). A study design using mixed methods takes into account the multiple views of our social world and the many ways in which data is collected to answer the research question(s). Using convergent parallel mixed methods, I collected qualitative data through interviews with key informants and observation of the care environment and quantitative data through surveys among migrant patients and health care providers in parallel and then analysed, compared and interpreted the findings after the completion of the fieldwork.

While the results sections (Chapters 4-7) present the quantitative and qualitative findings independently, the interpretation involved assessing, interrogating and reflecting on the quantitative and qualitative findings in an iterative process. The interpretation of the qualitative and quantitative findings was informed by the study's conceptual framework (Figure 2), and the study objectives, with a particular emphasis on how the findings converge and/or diverge (144). Establishing the convergence and/or divergence of findings is the hallmark of the convergent parallel design in a mixed methods study (143). In this thesis, the comparison, integration and interpretation is presented in the discussion section (Chapter 8). The mixed methods convergent parallel design is shown in Figure 4.

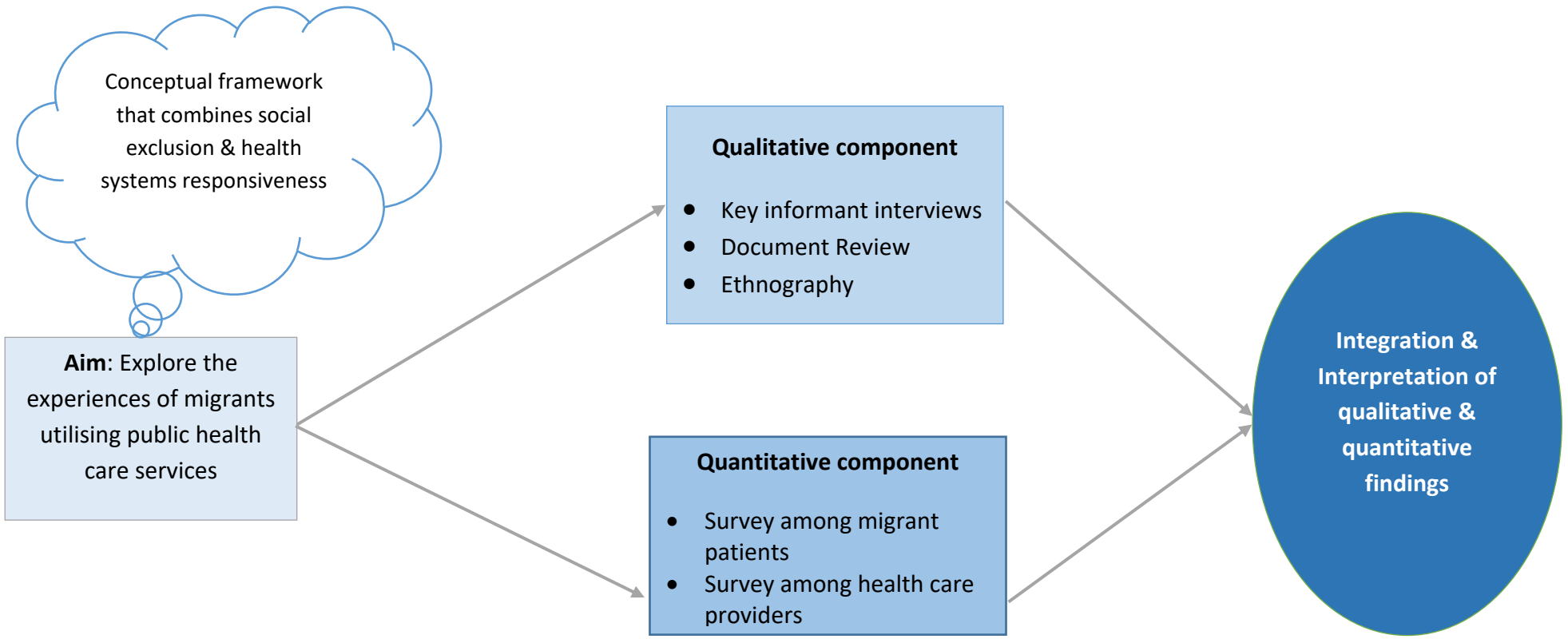


Figure 5: Overview of PhD mixed methods study components

3.5 Qualitative component of the PhD study

The purpose of the qualitative component was threefold: Firstly, using a social exclusion lens, review key legislation and policy documents, and explore the perspectives of key informants on health care access, utilisation of health services by migrants, UHC, social exclusionary processes, and the role of health policy actors (Chapter 4). Secondly, explore the physical, social and cultural environment of health care provision for migrants, and its intersection with the behaviours of health care providers and migrant patients (Chapter 5). Lastly, using the qualitative study findings to interrogate and reflect on the quantitative findings, and integrate all results to meet the overall study aim (Chapter 8).

The details of the qualitative methodology are contained in Chapters 4 and 5. In this section, a high-level summary is provided.

3.5.1 Key informant interviews and document review

Figure 5 provides an overview of the key informant interviews and document review, used to answer PhD **objective 1.** Further details are contained in **Chapter 4.**

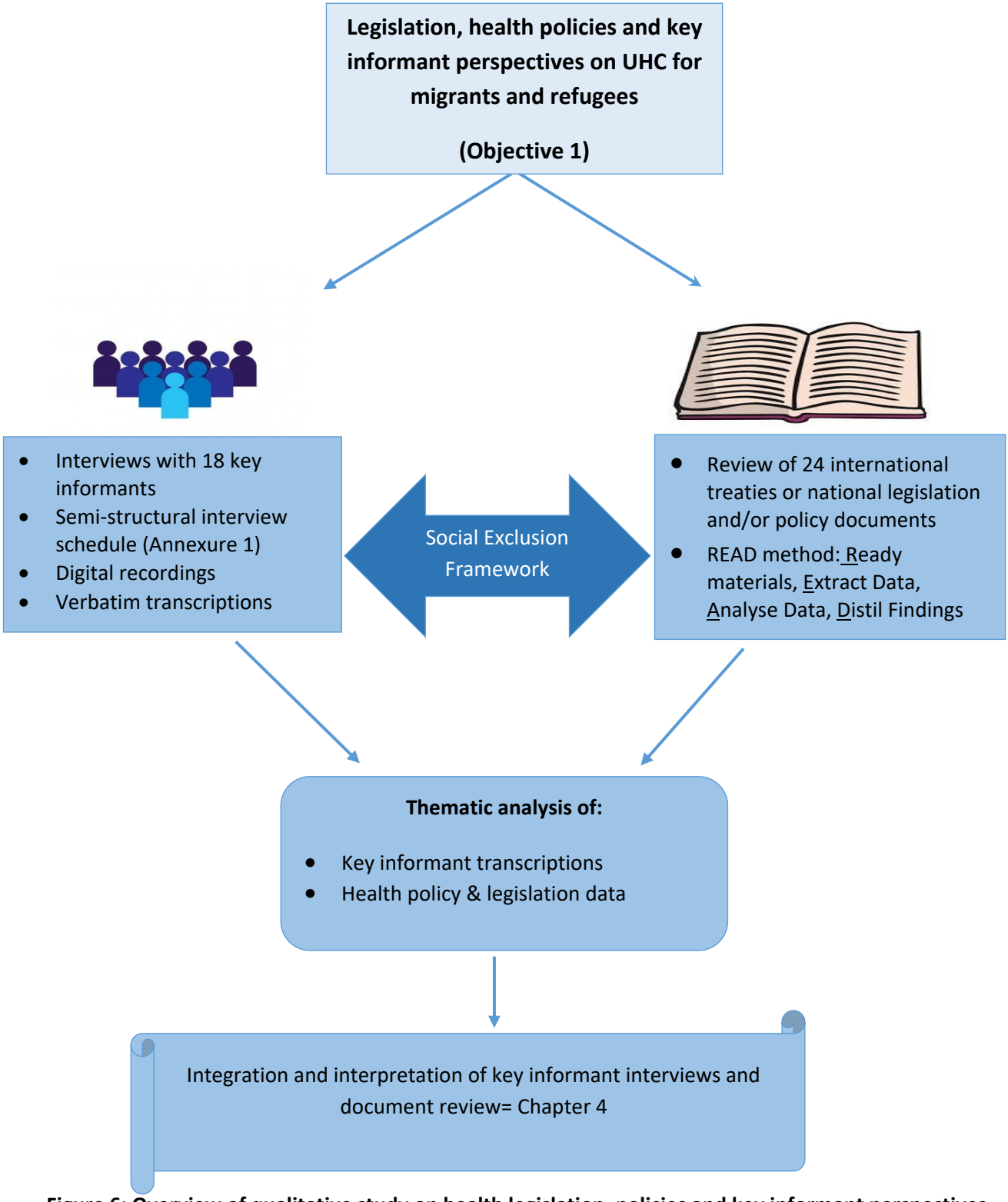


Figure 6: Overview of qualitative study on health legislation, policies and key informant perspectives

3.5.2 Ethnographic study

Figure 6 provides an overview of the ethnographic study that aimed to explore the environment of health care provision for migrants and the everyday practices and behaviours of health workers and patients at the 13 public health facilities in Gauteng. Further details are contained in **Chapter 5.**

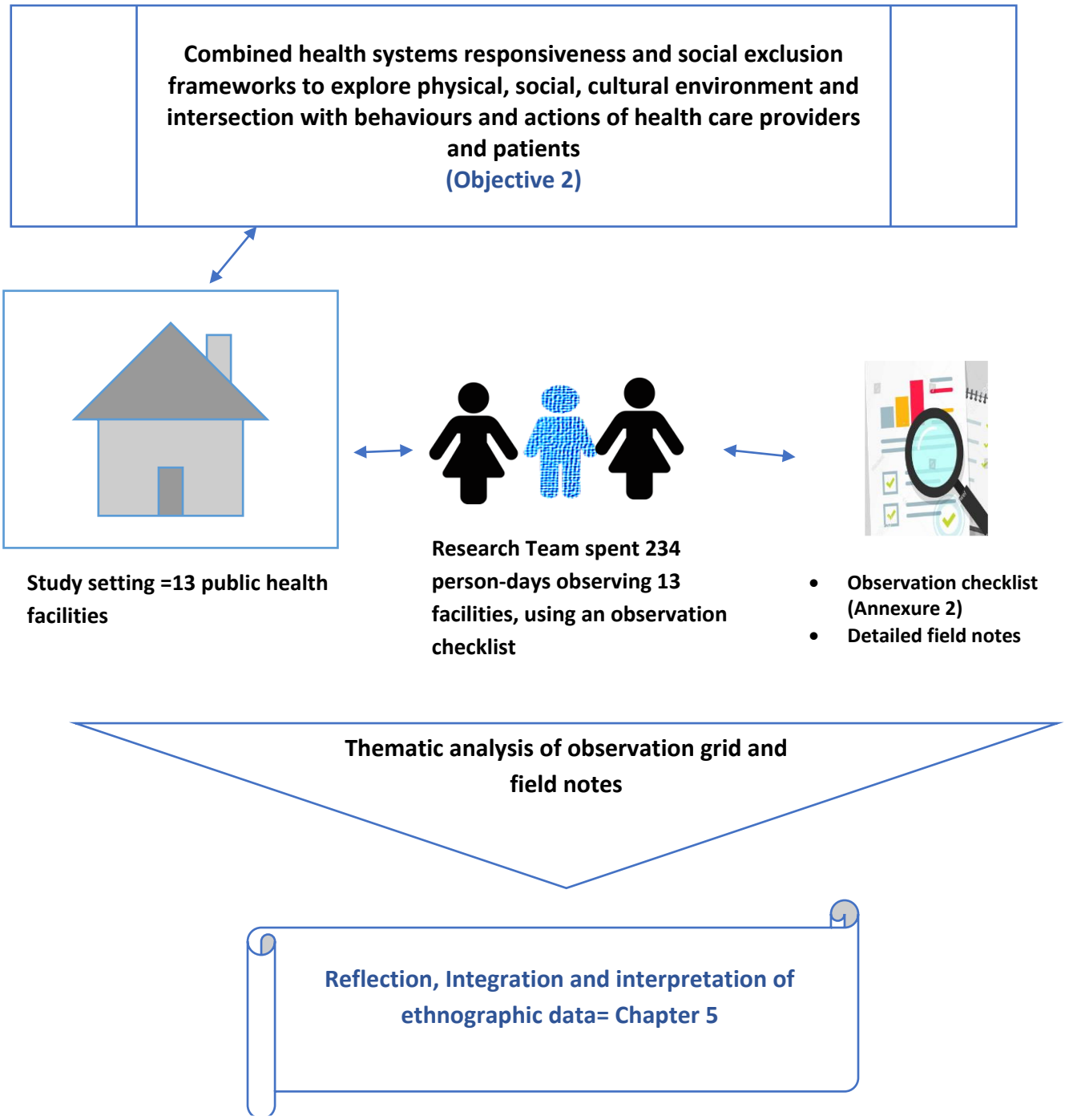


Figure 7: Overview of ethnographic study on environment of care provision

3.5.3 Data management of the qualitative study

All qualitative data was securely stored during this study. The key informant interview were recorded digitally, using an application (Voice Memos) on a secure mobile device. The mobile device offered a double layer of protection: fingerprint access and key code. Following the interviews, the audio files were downloaded and stored on a password protected laptop. Similarly, transcriptions of the audio recordings were secured on the same password protected device. The associated notes pertaining to the key informant interviews were stored in an access controlled and locked office. All handwritten field notes from the ethnographic observations were stored in an access controlled and locked office, and then once entered into grid format on MS Excel, was secured on a password protected laptop.

Table 6 summarises the data management and quality assurance used for the qualitative component of my PhD.

Table 6: Data management and quality assurance for the qualitative study

Key informant interviews

- Audio recorded via Voice Memos.
- Audio recordings transferred from mobile device to laptop at the end of each interview.
- Audio files transcribed into MS Word format.
- Reading transcriptions and listening to audio files to ensure accuracy.
- Establishing intercoder agreement with two external researchers.
- Back up of audio data files created and stored in Cloud.

Field notes from ethnographic observations

- Handwritten field notes collected at the end of each fieldwork day.
- Field notes stored in access controlled office.
- Field notes entered into MS Excel format.
- Cleaning of data in MS Excel.
- Establishing intercoder agreement with two external researchers.
- Back up of observational data created and stored in Cloud.

3.5.4 Reliability and validity

The seminal work of Lincoln and Guba (145) outlines the criteria to evaluate the quality of qualitative research to ensure that the findings could be incorporated into health care policy

and practice (146). The criteria are centred on trustworthiness with the purpose of establishing the credibility, confirmability, transferability, and dependability when conducting qualitative research (145).

In this study, *credibility* and *confirmability* were ensured through the triangulation of findings (145), i.e. the collection of both quantitative and qualitative data. Similarly, the interview schedule (Annexure 1) and the observation checklist (Annexure 2) ensured that the same information was collected. Additionally, peer debriefing (147) was applied during analysis whereby external analysts were used - through the systematic process of intercoder agreement - to establish confidence in the qualitative data. Peer debriefing allowed for the exploration of data through the multiple lenses of analysts. Furthermore, the ethnographic observations in this study allowed for "persistent or pro-longed engagement", a term Lincoln and Guba (145) used to describe long-term engagement in the field and the opportunity it presents to observe the context and setting and to examine data objectively against those observations. Lastly, the PhD's conceptual framework (Figure 2) provided an opportunity to explore the experiences of migrants utilising public health care from multiple theoretical perspectives.

Transferability was achieved through a "thick description" (145) of the qualitative data, which involved the detailed accounts of the experiences of migrants utilising public health care, from the perspective of migrants, that of key informants who may shape utilisation of health care for migrants through their [key informants] role or influence in policy and legislation, and the observations of the health care environment. Additionally, peer debriefing (described in the paragraph above) also ensured transferability of the qualitative study.

The *dependability* of qualitative research rests upon the principle that a clear audit trail of the research is available and can be assessed by individuals who are external to the study, with the purpose of establishing that findings are consistent and reproducible (145). The dependability of the qualitative component in this PhD study was confirmed in two ways. Firstly, through the presentation of the research methods at three key points in this PhD journey for review, i.e. at the protocol phase; the Faculty Graduate Studies Committee; and the Human Research Ethics Committee (HREC) (Medical). Secondly, an interim seminar (a requirement of the PhD programme) was done to mark the mid-point of the PhD study.

During this seminar, the preliminary findings along with an outline of the steps taken during the research process (audit trail) were reported to two external assessors for review. Validity of the qualitative components of the PhD study was also ensured through the presentations described above and established that the data collection tools, the steps taken during the research process and that the data collected were valid and indeed, appropriate to answer the research objectives (148).

Throughout this PhD journey, I constantly embarked on a process of reflexivity, which involved reflection on my preconceptions and how this might shape the findings of the study. Peer debriefing became a critical component of this reflexivity as I was constantly challenged to look at the data through the multiple lenses that the analysts brought during the process of intercoder agreement.

The steps outlined above were critical to affirming the trustworthiness of the qualitative study (145).

3.6 Quantitative component of the PhD study

The purpose of the quantitative component was twofold: firstly, determine the experiences of migrants utilising health care services in Gauteng public health facilities (Chapter 6) and secondly, to determine the health care providers' perceptions of delivering health services to migrants in public health facilities in the Gauteng Province of South Africa (Chapter 7).

3.6.1 Overview of surveys

Table 7 provides and overview of the two surveys, with more details provided in Chapters 6 and 7.

Table 7: Overview of migrant patient and health care provider surveys

Survey component	Migrant patient survey	Health care provider survey
Study setting	13 randomly selected public health facilities in Gauteng Province.	
Study population	Migrant patients utilising ambulatory care in selected health facilities on the fieldwork days.	All health care providers working in ambulatory care in selected health facilities on the fieldwork days.
Data collection tool	Semi-structured questionnaire (Annexure 3) eliciting information on: • Socio-demographic characteristics. • Perceptions of HSR. • Satisfaction with health workers. • Open-ended comments on any aspect of health care visit and recommendations.	Self-administered questionnaire (Annexure 5) eliciting information on: • Socio-demographic characteristics. • Perceptions on discrimination and/or differential treatment of migrants. • Perceptions on a range of social exclusionary statements regarding migrants.
Pilot study	Yes among patients at facilities not part of the study.	Yes, among health care providers not part of the study.
Data collection	• Informed, written consent (Annexure 4). • Survey administered to migrant patients using the REDCap application downloaded on a mobile device.	• Informed consent (Annexure 6). • Health care providers completed self-administered questionnaire on mobile device.
Quantitative data analysis	• Stata® 15. • Descriptive statistics computed of demographic characteristics, migrant patients' perceptions of HSR and satisfaction with health workers. • Multiple logistic regression and ordinal logistic regression models to examine the factors associated with patient perceptions of HSR and the relationship between perceptions of HSR and satisfaction with health workers.	• Stata® 15. • Mean and standard deviations: dispersion of social exclusionary views or practices among HCPs. • Multiple regression model: relationship between health care provider characteristics and social exclusionary view or practices.
Qualitative data analysis	Thematic analysis.	-

3.6.2 Data management and quality assurance of the quantitative studies

REDCap (Research Electronic Data Capture) - a secure web application for building and managing online surveys (149) - is password-protected, and was used for the two surveys. All tablets used for patient and health care provider survey administration were password protected, thus providing a double-layer of security for all surveys. At the end of each fieldwork day, I collected the tablets from the research team and ensure synchronisation of the data collected for the day onto the REDCAP server.

Table 8 summarises the data management and quality assurance used for the quantitative component of my PhD.

Table 8: Data management and quality assurance for the quantitative component

Patient survey

- Patient survey uploaded to REDCap for data collection.
- Patient data synced from tablets to REDCap server at the end of each field work day.
- Patient data exported from REDCap to Stata.
- Patient data cleaned in Stata.
- Back up of migrant data files created and stored in Cloud.

Health care provider survey

- Health care provider survey uploaded to REDCap for data collection.
- Health care provider data synced from tablets to REDCap server at the end of each field work day.
- Health care provider data exported from REDCap to Stata.
- Health care provider data cleaned in Stata.
- Back up of health care provider files created and stored in Cloud.

3.7 Integration of qualitative and quantitative findings

The integration of quantitative and qualitative findings was the final step in the PhD study. I used triangulation to integrate the qualitative and quantitative components of this study. Denzin defines triangulation as “the combination of methodologies in the study of the same phenomenon” (150 ,p.291), serving the purpose of providing “a more detailed and balanced picture” (Altrichter et al, 1996, p.117) when investigating a phenomenon (in this case

migrants' perceptions of HSR and experiences of social exclusion). Triangulation involved capturing the voices of migrant patients, health care providers (at the 13 public health facilities) and key informants (with a document review) and this was a vital part of achieving the overall PhD study aim. In this study three types of triangulation were applied, namely, theoretical or conceptual, methodological and data triangulation. Table 9 shows a brief description of each of the triangulation types used and their application in this PhD study.

Table 9: Description of triangulation and application in PhD study

Type of triangulation	Description of triangulation	How it was applied in this PhD study
Theoretical triangulation	The use of more than one theoretical framework when exploring or investigating a phenomenon.	The study uses an overall health systems approach, and adapted the SEKN social exclusion model (8) and HSR conceptual framework (74).
Methodological triangulation	The use and collection of both qualitative and quantitative data to answer the different research objectives.	• Qualitative data was obtained through key informant interviews, a document review of health policy and legislation, ethnographic observations, and asking migrant patients to comment freely on their health care consultations. • Quantitative data was obtained through the surveys among migrant patients and health care providers.
Data triangulation	Merging across the qualitative and quantitative findings or confirmatory role of qualitative and quantitative findings.	• Comparison, divergence and merging the qualitative findings from the interviews, document review, ethnographic observations, and open-ended responses from migrant patients; and the quantitative findings from the surveys among migrant patients and health care providers.

3.8 Research ethics and ethical considerations

There were three critical considerations during the research that merited attention: conducting the PhD study in an ethical manner; the ethics of conducting research among vulnerable populations; and my reflexivity and positionality.

3.8.1 Conducting the PhD study in an ethical manner

Ethics approval to conduct the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (HREC) Medical (Certificate #: M170988) (Annexure 7). Subsequent to the HREC Medical approval, and in line with the requirements of the National Health Act, an application was submitted to the National Health Research Database (NHRD) for permission to conduct the study at the 13 public health facilities (151). The database serves as a central location for all health research conducted in South Africa (152). Permission to conduct the study at the 13 public health facilities was granted in October 2017 (NHRD reference #: GP_201804_019) (Annexure 8). In addition, each CEO or manager of the various facilities granted permission in writing to conduct data collection in the respective facilities.

This study was guided by the principles contained in the Singapore Statement on Research Integrity (153). The values espoused in the Statement are to uphold the principles of "honesty, accountability, professional courtesy and fairness, and good stewardship" (153 ,p.72) . All ethical procedures were adhered to during this study. These included the voluntary participation of key informants, migrants and health care providers; ensuring that their rights involved in participation were maintained, and ensuring confidentiality and anonymity of all participants and study information in the study.

All participants in this study were provided with an information sheet containing information specific to the respondent (Annexures 4, 6 and 8). The information sheet was developed to inform potential participants about voluntary participation in a clear and transparent manner, including information about the study - what the study is about, why the study is being conducted, participants' rights in the study, and potential harm.

All potential respondents who agreed to participate in the study gave written consent before actual data collection commenced, i.e. completion of the survey or sitting down for the

interview. Patients and health care providers were prompted at the beginning of the survey on the REDCap application, to indicate by selecting 'yes' or 'no' whether they consented to participating in the survey. Given that the questionnaire is completed electronically, the selection of 'yes' to indicate agreement with participation in the survey is considered written consent. All participants were reminded of their rights in study participation, which included their right to refuse to participate without prejudice to them. By giving written consent, the participant acknowledged that he/she voluntarily took part in the study.

The information participants provided in the study will remain confidential, and no personal identifiers were collected in the study. Each completed survey (for patients and health care providers) and audio file (for key informant interviews) was assigned a unique code. Additionally, all health care facilities were also assigned with a unique identifier to ensure confidentiality and anonymity. All data were stored on a password-protected laptop. The survey data were stored on the secured REDCap server, with access granted with log in credentials (username and password), giving a double layer of security. Similarly, the REDCap application on all mobile tablet devices also had log in credentials and was only accessible to the research team and myself.

3.8.2 The ethics of research among vulnerable populations

Migrants are considered a vulnerable population that is, a group at increased risk for poor physical, psychological, and social health outcomes and inadequate health care (154). In recognition of these vulnerabilities, I adapted an existing distress protocol (155), and developed a set of procedures to guide research interactions with migrant patients in the event of psychological distress, for example, crying (Annexure 12). The distress protocol contained the algorithm for the steps to be taken in the event of a migrant patient showing distress during the recruitment phase of the research. In the first step, a seat should be found for the patient who is showing distress. Once seated, the reasons or trigger for the reaction should be established and any reference to the research process should be stopped. At this point, and with the consent of the patient, a health care worker should be called for assistance.

An important element during data collection was to build trust and rapport and to provide a comfortable and private space for study participants to complete the survey. The private surroundings and conducting individual interviews helped to provide the necessary privacy and trust. In addition, an advantage was that the health care authorities did not employ the research team, and participants talked freely about their experiences.

Given this sensitive approach to data collection with migrants in particular, the research team did not encounter any incidents of distress among migrant patients.

3.8.3 My own positionality and reflexivity

Reflexivity is a critical and valuable part of any research undertaking, and may be defined as an ongoing process in research through the researcher's practice of self-reflection and the act of thinking about their preconceived ideas, actions and feelings (147).

I came into this PhD study as a social scientist and master's graduate, having conducted my master's research study on migrant women, mental disorders and xenophobic violence. Some women shared their experiences of poor treatment when utilising public health care facilities. I am deeply committed to protecting the human rights of migrants. I commenced my PhD with some preconceived notions of migrants' experiences when utilising public health care services in South Africa, and expected to find uniformly poor treatment of migrants. During the pilot phase of my PhD study, I was surprised to see rude and disrespectful treatment of female nurses by male migrant patients. This made me realise the complexity of migrant patient and health care provider interactions, within the context of a distressed public health care system.

I embarked on a constant process of self-reflection of my privileged position as a researcher, PhD student, and academic. I became aware that my roles and own positionality could influence my PhD study, and my approach to study participants. In the case of migrant patients, they could view me as a potential ally to whom they could open up about their experiences, or see me as a potential threat to their utilisation of the public health care system. For example, migrant patients could think that I would share their data with health authorities or that participation in the study could influence their subsequent visits to the

health facility. In the case of health care providers, they could see me as adding to the burden of care provision, by having to complete a self-administered questionnaire, or that they had to behave in a particular way while we were present and observing them.

I was transparent about my role as a PhD student and researcher, emphasising that participation in the study was voluntary, that all information provided was confidential and would be reported anonymously. I also stressed that that there would be no benefits to, or risks of, taking part in the study. During the observations, we tried to be as unobtrusive as possible.

My self-awareness became more apparent as I reflected on myself as part of the research process and about my own perspectives and preconceived ideas. I worked hard to ensure immersion in the data, constant reflection, peer review, debriefing with my supervisor and an iterative process during analysis to ensure that my own biases did not influence the findings.

Additionally, the range of research methods ensured that I was able to triangulate the different findings. These methods included drawing on conceptual frameworks to inform my data collection tools, conducting pilot studies, using both qualitative and quantitative methods of inquiry across a range of actors including migrants themselves, and for the qualitative analysis, ensuring the rigour and trustworthiness of the data through activities such as intercoder agreement.

Conducting research in public health facilities was not an easy task. In some instances, I witnessed the stark reality of an emergency room on a Sunday morning, filled with major injuries (stabbings, gunshot wounds). It was here that I watched the situation unfold as a frail, male patient (in a wheel chair) who had been in the emergency room for several hours was frantically rushed into the resuscitation room (potentially with a weak or absent pulse). It was harrowing to watch this unfold. In another situation at a different hospital, I was told to put gloves on and help restrain a difficult patient who did not want to lay on the stretcher after he had passed out while waiting to be seen in the ER. I am not a medical professional (level 3 first aider) and it was a difficult decision to make, but I helped to restrain him even though it made me feel uncomfortable. I felt that I had to help and so I did.

The opportunity to debrief with my supervisor was a critical part of returning from the field (between fieldwork days) and it was an ongoing process throughout the PhD journey. It gave me the chance to talk about my experiences in a safe space. Most importantly, the act of debriefing allowed me to think about my role as a researcher, my subjectivity in a way that enhances transparency, thereby giving credibility to the findings from my study. Strategies such as "peer debriefing; audit trials; member checking; and reflexivity" promote the rigour of research undertaken in addition to ensuring the credibility of the study findings (147).

3.9 Potential bias, limitations and amelioration

This section outlines the potential bias, the study limitations, and the steps taken to mitigate potential bias and address limitations.

3.9.1 Potential bias and overcoming bias

In this study, the potential sources of bias were non-response bias, social desirability bias, observer bias and observation bias. Bias is defined as "Any process at any stage of inference which tends to produce results or conclusions that differ systematically from the truth" (156 ,p.60).

Non-response bias. Non-response bias occurs when those who do not participate in the study are systematically different from participants who do respond (156). In order to mitigate for potential non-response bias in the migrant and health care provider surveys, the questionnaire was designed to be short, items were concise and could be easily understood by participants. Additionally, the survey was uploaded onto the REDCap application on mobile tablet devices and completion of the survey involved using the touch screen, allowing for seamless, quick and confidential completion. Other techniques to mitigate for non-response bias included building rapport with migrant patients and health care providers. In the end, both surveys obtained response rates in excess of 80%, thus ensuring representativity.

The self-reported information obtained from migrant patients and health care providers may have been influenced by **social desirability bias**. Survey participants may either over-report or under-report to portray themselves in a favourable light, that is contrary to their practice (157). The questions in both surveys were phrased in a way to obtain an honest answer or reflection from the participants. All participants in the study were informed and reassured

before giving consent to participate in the study that their responses were confidential. In the case of the health care provider survey, the potential for social desirability bias was reduced because the survey was self-administered. Similarly, in the case of the key informants, there was also the potential for social desirability bias. This was mitigated by posing the questions in such a way to elicit an honest response and I balanced this with using probes to get key informants to expand on their answers. Furthermore, the key informants held senior positions in their respective work settings, thus removing the potential bias of a power imbalance with me as the principal researcher.

Observer bias was a potential source of bias in the patient survey, which was administered by fieldworkers to patients (researcher-administered). In order to minimise this type of bias, I used a standard, semi-structured questionnaire (survey); ensured that all fieldworkers were trained; and ensured privacy during completion of the survey. Observer bias did not arise for the health care provider survey, because they completed the survey via the REDCap application on the mobile device.

Observation bias was a potential source of bias in the ethnographic observations. Observation bias in the ethnographic observational study could occur when there are systematic differences in the recorded observations " during the process of observing and recording information for a study" by multiple observers (158 ,p.23). In order to reduce observation bias, all observers were trained before fieldwork commenced. Additionally, an observation guide was used for data collection to ensure standardisation of the observations, while also allowing for flexibility for observers to include information not contained in the guide. The training of fieldworkers and the use of an observation guide are referred to as "standardized protocols for data collection" and thus, minuses the variations between multiple observers (159).

3.9.2 Study limitations and amelioration

In this study the limitations included the cross sectional nature of the study, the migrant patient survey conducted in English, generalizability of the migrant patient survey findings; the exclusion of level of income and employment from the migrant patient survey; the study was conducted in one Province and the small number of participants in the key informant study.

The **cross sectional** nature of the study is a limitation as it gives us a snap shot of the migrant patients, health care providers and key informants' perspectives at the time the study was conducted. Although a cross sectional design does not allow causal inferences, it provides a valuable baseline of the socio-demographic profile of migrants utilising public health care services in Gauteng Province, i.e. by age, gender, length of duration in South Africa, and level of education. Future studies could examine whether and how migrant patients and health care providers' perspectives vary over time.

The migrant survey was **conducted in English**, which is a second language for migrants. This may have limited their ability to expand on their responses. In order to mitigate this, the survey questions were simplified and researcher-administered; thus participants had the opportunity to ask for clarification on questions.

The study among migrant patients examined the perspective of migrants already **utilising health services rather than issues of access**. Thus, the findings are not generalizable to all migrants. Nonetheless, the study provides important findings on migrants' experiences when utilising public health care services in Gauteng Province.

Another limitation is that **level of income and employment were excluded** from the study among migrant patients. As a result, the socio-economic status of migrant patients was not explored. Nonetheless, a range of other socio-demographic and other patient characteristics were included in the survey and allowed for a robust exploration of factors associated with migrants' perceptions on HSR and satisfaction.

Another limitation is that the study was **conducted in one province of South** Africa, i.e. Gauteng Province, thus findings may not be representative of other provinces. However, Gauteng is the preferred destination for almost one in two international migrants. Hence, this PhD study provides important insights into migrant experiences, as well as a baseline in subsequent studies. Other researchers could use the tools developed for this PhD study in future studies. Moreover, the economic and social importance of Gauteng means that the study findings may contribute to the notion of a migrant-friendly health system, and the UHC policy discourse.

The findings from the key informants study was obtained from **a relatively small number of participants** and is a limitation of this study. Although key informants were from different sectors or categories, most civil society organisations were located in Gauteng Province, and there was one participant from a UN organisation. Thus, the key informants' perspective may not be transferable to other provinces. However, data saturation was reached after 10 interviews.

Importantly, as a researcher, I have dealt with all potential sources of bias and limitations pro-actively, and made every effort to prevent or ameliorate these.

The scholarly contribution and strengths PhD study are elaborated on in Chapter 8.

CHAPTER 4: POLICY EXCLUSION OR CONFUSION? PERSPECTIVES ON UNIVERSAL HEALTH COVERAGE FOR MIGRANTS AND REFUGEES IN SOUTH AFRICA

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Policy exclusion or confusion? Perspectives on universal health coverage for migrants and refugees in South Africa

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Abstract

Notwithstanding the promise of the inclusivity of universal health coverage (UHC), the integration of migrants and refugees into host countries' health systems remains elusive and contested. In South Africa, there is insufficient scholarly attention on UHC, migrants and refugees, given the country's strategic importance in Africa and the envisaged implementation of the National Health Insurance (NHI) system. In this paper, a social exclusion conceptual framework is used to explore whether South African legislation, health policies and perspectives or actions of health policy actors facilitate UHC for migrants and refugees or exacerbate their exclusion. We combined a review of legislation and policies since 1994, with semi-structured interviews with 18 key informants from government, academia, civil society organizations and a United Nations organization. We used thematic analysis to identify themes and sub-themes from the qualitative data.

The South African Constitution and the National Health Act facilitate UHC, while the Immigration Act and the 2019 NHI Bill make the legal status of migrants the most significant determinant of healthcare access. This legislative disjuncture is exacerbated by variations in content, interpretation and/or implementation of policies at the provincial level. Resource constraints in the public health sector contribute to the perceived dysfunctionality of the public healthcare system, which affects the financial classification, quality of care and access for all public sector patients. However, migrants and refugees bear the brunt of the reported dysfunctionality, in addition to experiences of medical xenophobia. These issues need to be addressed to ensure that South Africa's quest for UHC expressed through the NHI system is realized.

Keywords: Universal health coverage, migrants, NHI, South Africa, social exclusion

Introduction

Universal health coverage (UHC) is a key target of the United Nations' Sustainable Development Goals, contributing to the reduction of health inequities and improvements in population health outcomes (United Nations, 2019, p. 6). UHC means that all people receive the quality health services they need, while ensuring that health service utilization does not expose users to financial hardship (WHO, 2019, p. 7). UHC embodies the concepts of equity, quality and financial risk protection (WHO, n.d.) and is intended to 'leave no one behind' (WHO, 2019, p. 7). This inclusive nature of UHC was captured in the political declaration of the 2019 high-level meeting on UHC (United Nations, 2019) and implies the prioritization of vulnerable groups, such as migrants (WHO, 2019; United Nations, 2019). However, achieving UHC is complex, influenced by country context and different meanings of the concept. UHC implementation requires clarity on prioritization, regulatory frameworks, financing mechanisms and potential trade-offs given resource constraints in many countries (Jha *et al.*, 2016; Norheim, 2016; Rispel, 2019; Rumbold *et al.*, 2017).

The 2018 Lancet Commission on Migration underscored the responsibility of governments to uphold human rights and provide equitable UHC to migrant populations, regardless of their legal status (Abubakar *et al.*, 2018). Despite the promise of the inclusivity of UHC, the integration of migrants and refugees into host countries' health systems remains elusive and contested (Wickramage *et al.*, 2018; Legido-Quigley *et al.*, 2019). In this study, we refer to migrants as individuals who have moved across an international border away from their place of residence, regardless of their legal status, the voluntary nature of movement and/or the causes for the movement (International Organization for Migration, 2019). The United Nations defined a refugee as 'someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion' (United Nations, 1951, p. 3). In practice, a refugee refers to an individual with formal documentation who has been granted refugee status by the host country.

In recognition of the social exclusion of migrants and refugees from health policies, the 2019 World Health Assembly agreed that one of the key priorities in all Member States

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Key messages

- A social exclusion conceptual framework is a useful analytical tool to explore universal healthcare for migrants and refugees, by focusing attention on the structural drivers of exclusion, the processes that generate unequal power relationships, the policy actors that drive exclusion and the intersection among all of these.
- Despite a right-based and non-discriminatory constitution and an enabling National Health Act in South Africa, both the Immigration Act and the 2019 NIH Bill make legal status of migrants the most significant determinant of their healthcare access.
- The intersection of under-investment, resource constraints and perceived dysfunctionality of the public health sector contribute to the exclusionary behaviour and actions of frontline health workers against migrants and refugees.
- The reported discrimination and stigma experienced by migrants and refugees include the request for identity documents, financial misclassification, discretionary healthcare access, denial of treatment, and in some instances name-calling and outright discrimination by frontline health workers.

should be to mainstream migrant and refugee health into health policies (World Health Organization, 2019). However, research studies have documented the entire spectrum of health policies in countries, from those that are inclusive of all migrants regardless of their legal status, to much more restrictive policies, eroding the principles of UHC (Legido-Quigley *et al.*, 2019; Cabieses *et al.*, 2019; Yaya and Sanogo, 2019).

In the European Union (EU), several studies have found considerable variation in healthcare access for migrants and refugees, between and within EU Member States (Cuadra, 2011; Woodward *et al.*, 2013; De Vito *et al.*, 2015; Keith and Van Ginneken, 2015; Cimas *et al.*, 2016; Hannigan *et al.*, 2016; Geeraert, 2018; Ledoux *et al.*, 2018). A 2016 review of countries in the EU found that legal status was one of the most significant factors that influenced migrants' access to comprehensive health services (Hannigan *et al.*, 2016). Within the EU, undocumented migrants mostly had access to emergency care, but both formal and informal barriers hindered access in countries with UHC (De Vito *et al.*, 2015). These barriers included differing interpretation and implementation of health policies, language and communication problems, lack of social networks, migrants' fears, and lack of knowledge about their rights, the healthcare system and healthcare professionals (De Vito *et al.*, 2015; Woodward *et al.*, 2013).

In low-and middle-income countries, there is emerging literature on migrants, refugees, health policies and UHC (Guinto *et al.*, 2015; van Hees *et al.*, 2019; Vijayasingham *et al.*, 2019). A 2015 study on the inclusion of migrants in the UHC systems of Indonesia, Malaysia, Philippines, Singapore and Thailand found variations in healthcare coverage of migrants and implementation challenges (Guinto *et al.*, 2015). Notwithstanding Thailand's success in expanding insurance coverage to undocumented migrants, key challenges included unclear policy messages, bureaucratic hurdles, inadequate coordination and the inconsistent practices of frontline implementers (Suphanchaimat *et al.*, 2015).

In Africa, post-colonial African migration is predominantly intraregional, with South Africa and Nigeria as the leading destination countries (Abebe, 2017). The African Union's draft 2018–2027 migration policy framework for Africa recommends that migrants should have access to national healthcare systems, but the authors underscore the need for further research on the intersection between the vulnerabilities of migrant populations, healthcare access and entitlement to basic health services (African Union, 2017).

South Africa has a two-tier healthcare system, consisting of an under-resourced public health sector that provides care to around 84% of the population, and a well-resourced private health sector that serves around 16% of the population with access to private health insurance (The Presidency, 2019). Notwithstanding numerous transformation efforts since South Africa's democratic transition in 1994, it remains one of the most unequal countries in the world (The Presidency, 2019). The 2019 report of the Health Market Inquiry (HMI) provides evidence of the inequities in resource availability and healthcare provision between the public and private health sectors, and the need for major reforms (Competition Commission of South Africa, 2019). Similarly, the 2019 report of the South African Lancet National Commission provides a detailed diagnosis of quality of care gaps and emphasizes the need for, and the transformation potential of, quality UHC in the country (South African Lancet National Commission, 2019). Both the HMI and Lancet National Commission reports underscore the necessity of UHC reforms enunciated in the National Development Plan (NDP) (National Planning Commission, 2011). The proposed National Health Insurance (NHI) system aims to give effect to the progressive realization of the right to healthcare enshrined in the South African Constitution (Republic of South Africa, 1996) and the UHC goals of the NDP (The Presidency, 2012). The proposed NHI system is a major financing reform aimed at overcoming the public–private health sector inequities and moving closer towards quality UHC (NDOH, 2017). NHI implementation is envisaged in various phases over a period of 14 years, with the draft NHI Bill released in 2019 to formalize the regulatory aspects of implementation (NDOH, 2019).

In the public sector, the nine provincial health departments are responsible primarily for health service provision, through a network of hospitals, health centres and primary healthcare clinics (The Presidency, 2019). Although the South African Constitution guarantees the right of access to healthcare services for everyone in the country (Republic of South Africa, 1996), in practice healthcare access for migrants and refugees in the public sector is intertwined with various laws, policies, migrants' socio-economic and legal status in the country and the behaviours and practices of government officials. Several researchers have highlighted the problems experienced by all categories of international migrants. These include the disjuncture between immigration and health legislation, the lack of or delays in obtaining official documents from the Department of Home Affairs, and the attitudes or actions of frontline immigration and/health workers. These problems impact on migrants' healthcare access, their experiences, and the ability of health providers to honour their ethical and professional obligations (Alfaro-Velcamp, 2017; Vearey *et al.*, 2018; Crush and Tawodzera, 2014; Zihindula *et al.*, 2015; Hunter-Adams and Rother, 2017). A 2020 published study that examined healthcare providers' perspectives on migrants in the public sector of Gauteng province found that the majority of

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these providers disagreed with the inclusion of migrants and refugees in the proposed NHI system and were of the opinion that migrants should return to their home countries for healthcare (White *et al.*, 2020a). Studies have also documented the deleterious experiences of migrants and refugees in the public health sector, characterized by inadequate access to essential treatment, medical xenophobia, discrimination and language barriers (Hunter-Adams and Rother, 2017; Zihindula *et al.*, 2017; Faturiyele *et al.*, 2018). White and colleagues found that migrant patients' satisfaction with health workers in the public sector were influenced by the receipt of information about their condition: perception of polite treatment, the time spent in facility, and whether they received their prescribed medicines (White *et al.*, 2020b).

Set against the backdrop of South Africa's health sector reforms, notably the intended implementation of the NHI, and South Africa's strategic position in Africa, the aim of this study was to explore whether legislation, health policies and the perspectives or actions of health policy actors facilitate UHC for migrants or exacerbate exclusion, and reproduce inequalities and discrimination against migrants. This is part of a larger doctoral study on the experiences of international migrants, social exclusion and health system responsiveness in the public health sector of a South African Province.

Methods

Conceptual framework

In this study, we have adapted the conceptual framework of the Social Exclusion Knowledge Network (SEKN) (Popay *et al.*, 2008) to explore legislation, policies and the perspectives of health policy actors on migrants and UHC in South Africa.

Set up as part of the WHO's Commission on Social Determinants of Health, the SEKN highlighted the contested nature of the concept of social exclusion and the nuances in the discourses on social exclusion in different geographical regions (Popay *et al.*, 2008). The SEKN aimed to develop a definition of social exclusion with global relevance (Popay *et al.*, 2008). Consequently, the SEKN defined social exclusion as a relational concept in recognition of the interdependence of social systems and the centrality of individual and collective action in pursuing policies or actions to promote inclusive and cohesive social systems (Popay *et al.*, 2008). The SEKN defined social exclusion as follows:

> *Dynamic, multi-dimensional processes driven by unequal power relationships that operate along and interact across cultural, economic, political and social dimensions and at different levels. Exclusionary processes contribute to health inequalities by creating a continuum of inclusion/exclusion. This continuum is characterised by an unjust distribution of resources and unequal capabilities and rights required to create the conditions necessary for entire populations to meet and exceed basic needs; enable participatory and cohesive social systems; value diversity; guarantee peace and human rights; and sustain environmental systems* (Popay *et al.*, 2008, p. 36).

In concert with the relational perspective of social exclusion, our study views the health system in South Africa as a social system, with numerous actors and processes that influence UHC for migrants (Figure 1).

The original SEKN framework assumed that social exclusion processes operate in the context of pre-determined biological (e.g. age) and genetic determinants (Popay *et al.*, 2008). We have added to this context, migration as a social determinant of health (Figure 1), in recognition of its influence on both UHC, and ultimately health outcomes of migrants and refugees (Castaneda *et al.*, 2015).

The original SEKN framework describes four dimensions of overlapping and interconnected power relationships that constitute the continuum from inclusion to exclusion—economic, political, social and cultural (Popay *et al.*, 2008). We kept these four dimensions (Figure 1), but adapted the definitions, as these were too broad for the study purpose. In our study, the social dimension refers to relationships and views of social solidarity and support expressed for the inclusion of migrants and refugees in South Africa's NHI system, its vehicle towards UHC. The economic dimension considers issues such as access to income and livelihoods that influence migrants' access to the NHI. The cultural dimension focuses on the perspectives of policy actors on the acceptance and respect of diverse values and ways of living, including extreme views of stigma and discrimination. The political dimension includes the formal rights embedded in legislation, policies and practices and the conditions in which rights are exercised e.g. access to healthcare.

In our adaptation of the SEKN framework, we replaced differential exposure and vulnerabilities with UHC (Figure 1). We suggest that there is a two-way relationship between social exclusion processes and the behaviour and actions of actors and UHC for migrants and refugees. Put differently, UHC (which includes legislation and policies to mediate the actions of policy actors) could reduce social exclusionary processes, whereas inequities in healthcare access, quality treatment and financial risk protection (the essence of UHC) will exacerbate social exclusion. We replaced health inequalities with health outcomes. Drawing on WHO definition of UHC (WHO, 2019), we propose that there is a two-way relationship between UHC and the health outcomes of migrants and refugees. The lack of or exclusion from UHC will exacerbate health inequities and contribute to poor health outcomes. In contrast, UHC will ensure responsiveness to population health needs and achieve more equitable and optimal population health outcomes.

The drawbacks of the SEKN framework are that the definitions are broad, lacking specific criteria to measure social exclusion or its dimensions. The framework was also developed primarily to feed into the work of the Commission on Social Determinants of Health, and prior to the UHC discourse. Nonetheless, the SEKN conceptual framework has several analytical advantages. First, it focuses attention on the structural drivers of exclusion (e.g. laws and/or policies), the processes that generate unequal power relationships (how), the policy actors that drive exclusion (who) and the intersection among all of these (Popay *et al.*, 2008). Second, the framework is useful in highlighting a continuum of inclusion and exclusion, which avoids labelling of migrants and refugees as 'excluded', yet recognizes the agency of migrants and refugees in contributing to change. Last, the framework also enables the identification of active exclusionary processes (e.g. policies, outright discrimination, etc.) and passive exclusionary processes (e.g. hospital billing systems,

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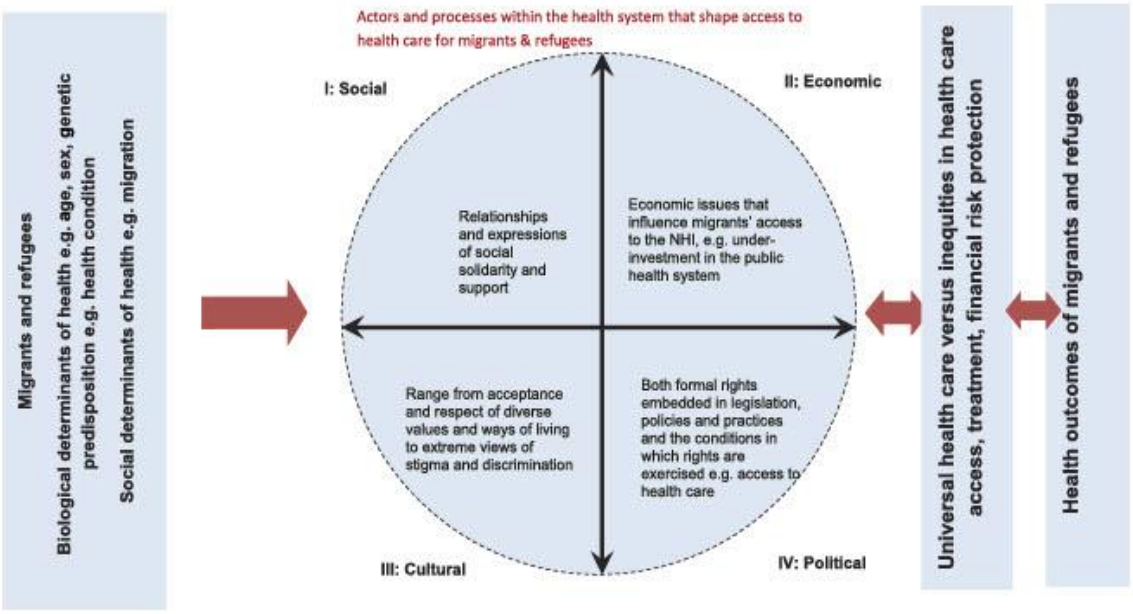


Figure 1. A social exclusion relational framework on migrants, refugees and the UHC in South Africa.
Source: Adapted from Popay *et al.* (2008).

lack of knowledge of existing laws or policies) (Popay *et al.*, 2008).

We used the adapted SEKN conceptual framework in the design of the interview schedule, and the thematic analysis of the documents, and the interviews.

Study design

A qualitative study design was used, which combined in-depth interviews with key informants (KIs) and a review of government legislation and policies on migrants and refugees. Each component is described below.

Key informants

The purpose of the key informant interviews (KIIs) was to explore the perspectives of key health policy actors on UHC and the NHI for migrants and refugees in South Africa. We developed a map of all the potential stakeholders, targeting knowledgeable individuals able to provide in-depth and rich information on migrants, their healthcare access, perspectives on social exclusion, and UHC and NHI in South Africa (Table 1). Hence, we compiled a list of 27 potential KIs.

Additionally, we used a snowballing technique, by asking KIs who agreed to interviews to recommend other potential KIs for interviews.

Informed by the adapted conceptual framework, we developed a semi-structured interview schedule covering questions on UHC, NHI, healthcare access for migrants and refugees, the drivers, processes and pathways of social exclusion; and policies, programmes and/or actions to address the health needs of migrants and eradicate social exclusion. The interview schedule was piloted with two participants who have similar profiles to the KIs. Based on the feedback and observations during the pilot, no changes were necessary.

Table 1. Map of key policy actors

Category	Possible number
Managers/government officials involved in Green Paper on migration or amendments to immigration bill	1
Senior government managers in Health, Presidency, Treasury, etc.	3
Members of NHI Ministerial task team	2
Managers in charge of mid-year population estimates at Statistics South Africa	1
Purposive selection of managers in charge of hospitals, health centres or clinics where health provider and patient surveys were conducted with at least one person from each type of facility	6
Civil society organizations focusing on or involved in: • Migration or migrant rights • Provision of services to migrants (e.g. legal advice) • Health governance structures	4
United Nations Agencies • International Organization of Migration • High Commission on Refugees	2
Academics/researchers focusing on: • Migration • Migrants' rights • Health or health services for migrants • UHC and NHI	8

The information from the pilot interviews was excluded from the analysis.

Potential KIs were contacted via email or phone for interviews. Following verbal agreements, each consenting KI was provided electronically with the study information sheet, consent forms for the interview and digital recording, and the interview schedule. The principal researcher (JAW) scheduled all the interviews at a mutually convenient time at a venue that ensured privacy during the interview. Following written

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informed consent for both the interview and the recording, the principal researcher conducted the interviews between March 2015 and December 2019. Six interviews were conducted between 2015 and 2017. Interviews for the remainder of KIs ($n = 12$) were conducted in 2018 and 2019. Because of the lapse of time since the analysis of the interviews in 2020, we sent the transcripts to the six KIs who were interviewed between 2015 and 2017 to validate their responses or to make any changes.

Each interview lasted an average of 1 hour, but the length of time varied depending on the responses of the KI. Interviews were recorded digitally with the participants' consent, and the principal researcher also took detailed field notes.

Ethical considerations and researcher positionality

The Human Research Ethics Committee (Medical) Ethics of the authors' institution provided approval for this. All study participants received a detailed information sheet and provided written consent for both the interview and the digital recording. The principal researcher informed each KI of the voluntary nature of the information and their rights as a study participant. The principal researcher ensured both confidentiality and anonymity of the interview data. The written consent forms are in a secure, locked cupboard, while the interview recordings and transcriptions are on a password-protected computer.

Both authors are employed at a large South African university. The first author is a PhD candidate, whose research focuses on migration as a social determinant of health, the mental health needs of migrants and how these intersect with the health system. The senior author was a member of the SEKN, the former head of a provincial health department, former head (dean) of a university school of public health and has extensive experience of health leadership, research and public health activism. Both authors are passionate about health equity and social justice but recognize the importance of data immersion, ethical research conduct and constant self-reflection.

The authors complied with all aspects of the Singapore Declaration on research integrity (World Conference on Research Integrity, 2010).

Review of legislation and policies

The purpose of the document review was to examine the content of legislation and policy documents to determine whether these laws and/or health policies were enabling or exclusionary. We used the United Nations and African human rights documents as the foundation for the review of the South African laws and policies. We focused on the period between 1994 and 2020, corresponding with the period of democracy. We assumed that these are the primary documents that shaped the policy and regulatory environment on migration, migrants, health and the South African healthcare system.

The document review took place between February and May 2020. We applied the READ approach—a systematic process to guide document analysis—to the document review (Dalglish *et al.*, 2020). The READ approach involves a systematic four step procedure in reviewing documents: (1) ready your materials, (2) extract data, (3) analyse data and (4) distil your findings (Dalglish *et al.*, 2020, p. 3).

Our first step was to ready our materials for the document review by searching for official and legal documents broadly pertaining to migrants, refugees and health, specifically legislation (international and national) and health policies. We identified 24 potential documents for inclusion in the review (Table 2). These documents were accessed through PubMed, Google Scholar and hand searching of the websites of the UN agencies, and the South African government. Following this initial identification of legislation and policies, the principal researcher then embarked on filtering through the documents to include those specifically related to regulations, rules or protocols on access, utilization and health coverage for migrants and refugees (criteria for inclusion).

In the next step, the principal researcher extracted the relevant information from the 24 documents and entered

Table 2. List of documents included in review

United Nations Human Rights Foundation documents ($n = 6$)

- 1948 Universal declaration of human rights
- The 1951 Convention Relating to the Status of Refugees and its 1967 Protocol
- International Covenant on Economic, Social and Cultural Rights, 1966
- Convention Governing the Specific Aspects of Refugee Problems in Africa, 1969
- International Covenant on Civil and Political Rights, 1976
- Protocols I and II to the Geneva Conventions of 1949 relating to the Protection of Victims of International and Non-International Armed Conflicts, 1949

Organization of African Union/African Union Human Rights or Migration Policies ($n = 3$)

- African (BANJUL) Charter on Human and Peoples' rights
- The migration policy framework for Africa, 2006 EX.CL/276 (IX)
- The revised migration policy framework for Africa and plan of action (2018–2027) *-draft*

The Constitution of the Republic of South Africa (1996) ($n = 1$)

Department of Home Affairs promulgated laws, White Papers or policies ($n = 7$)

- Refugees Act, 1998
- Immigration Act, 2002
- Immigration Amendment Act 19, 2004
- Immigration Amendment Act No. 13, 2002
- Refugees Amendment Act No. 33, 2008
- Immigration Amendment Act No. 13, 2011
- White paper on international migration for South Africa, July 2017

Department of Health promulgated laws, White Papers or policies Refugees Act, 1998 ($n = 7$)

- 1997 White Paper for the Transformation of the Health System
- National Health Act, No. 61 of 2003
- Green paper on National Health Insurance in South Africa, 12 August 2011
- 2015 White paper on the National Health Insurance for South Africa
- 2017 National Health Insurance Policy: Towards Universal Health Coverage (White Paper)
- National Health Insurance Bill, June 2018
- National Health Insurance Bill, July 2019

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the data into an MS Excel spreadsheet/grid. This process was guided by our adapted conceptual framework and out research question, i.e. whether legislation and policies facilitate UHC or exacerbate exclusion for migrants and refugees in South Africa.

Analysis

Audio files from the KIIs were transcribed verbatim in preparation for analysis. The principal researcher checked all transcriptions for accuracy and steered a process of both inductive and deductive coding during analysis.

The first step of analysing the KIIs was to apply a thematic framework analysis (Attride-Stirling, 2001), thereby generating an understanding of KIs' perceptions on migrants, social exclusion, UHC and the NHI. The principal researcher and three other researchers (including the supervisor LR) read and coded inductively three of the interview transcripts independently. These independent codes were entered into a grid and shared with all researchers, after which inter-coder agreement was reached. Codes were then grouped to form broader themes and sub-themes. The principal researcher then analysed the remainder of the interviews using the agreed upon codes and themes.

Second, we used the adapted SEKN conceptual framework and applied deductive analysis to the interview data. This deductive approach categorized the themes generated from the data according to concepts contained in the conceptual framework (Figure 1). The analysis was an iterative process, comparing and interrogating the inductive and deductive codes, and finally combining the process to obtain a comprehensive picture on the interview data.

A thematic analysis approach was applied to the document review (Braun and Clarke, 2006). Using a data extraction grid, information was aggregated from each policy or legal document. A key outcome was to explore the inclusion of migrants and refugees in healthcare legislation and/or policies. The data extraction was conducted by reviewing each document, examining the information considering the social exclusion conceptual framework and then inserting the relevant information into the grid. Consensus was then reached on the themes contained in the grid.

In the final step of the data analysis, the principal researcher used the adapted conceptual framework and a process of immersion and reflection in the triangulation of the data from the interviews and the document review. These steps in the qualitative data analysis for both datasets ensured the rigor of the research data, specifically credibility, transferability, dependability and confirmability (Lincoln and Guba, 1986).

Results

Eighteen KIs were drawn from five categories: tiers of government, including public hospitals ($n = 9$); academics or researchers ($n = 5$); civil society organizations ($n = 3$) and a United Nations (UN) Organization ($n = 1$).

Five inter-related themes emerged from the qualitative analysis: disjuncture between international treaties or declarations, the South African Constitution, and national legislation or policies; under-investment, overburdened and dysfunctional healthcare system; complexity and/or contradictory nature of migrant access to healthcare; pathways and processes of social exclusion; and migrant stereotypes, suspicions and discrimination. We present the findings from the document review and the interview themes in an integrated manner.

Table 3 shows the themes and sub-themes, and their alignment to the social exclusion conceptual framework.

Theme 1: disjuncture between international treaties or declarations, the South African constitution, and national legislation/policies

South Africa is a member of the United Nations, a signatory to the 1951 Convention on the Status of Refugees, its 1967 Protocol (United Nations, 1951), the International Covenant on Economic, Social and Cultural Rights (United Nations, 1976b), the International Covenant on Civil and Political Rights (United Nations, 1976a) and Protocols I and II to the Geneva Conventions of 1949 relating to the Protection of Victims of International and Non-International Armed Conflicts (United Nations, 1949). KIs from national government highlighted these country obligations.

The South African Constitution contains the Bill of Rights, applicable to all people in the country, regardless of their nationality or legal status (Republic of South Africa, 1996). Section 27 of the Constitution states that everyone has the right to have access to healthcare services, and no one may be refused emergency medical treatment (Republic of South Africa, 1996). Most KIs acknowledged the enabling nature of the South African Constitution but highlighted a disjuncture between an enabling Constitution and other laws, notably the Immigration Act (Department of Home Affairs, 2002) and the 2019 NHI Bill (National Department of Health, 2019). In line with the Constitution, the National Health Act is explicit that 'a health care provider, health worker or health establishment may not refuse a person emergency medical treatment' (National Department of Health, 2003). While the National Health Care Act does not distinguish between users and eligibility for free health services (National Department of Health, 2003), the Immigration Act makes provision for the identification of citizens or 'foreigners' and the request for documents prior to service provision, except in an emergency (Department of Home Affairs, 2002).

Moreover, the 2019 NHI Bill contains a clause on healthcare to 'migrants, refugees and asylum seekers, and illegal foreigners', but apart from emergency healthcare treatment and basic services, the Bill is vague on the healthcare entitlements of migrants and refugees (National Department of Health, 2019). Several KIs highlighted that the NHI Bill is potentially unconstitutional in that language such as 'illegal migrants or foreigners' used in the bill is discriminatory under-section 9 of the Constitution and therefore exclusionary. One of the KIs noted that although migrants are gaining access there is a disjuncture between that access and how they should be treated:

> *There appears to be some hospitals and facilities that are allowing or can't avoid a large number of foreign patients. A large number of those patients are illegal but they're gaining access [to the health facilities] in the context of a grey policy area. There isn't a clear, coherent framework in place as to how they should be treated* (key informant #14, academia).

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Table 3. Themes, sub-themes & their alignment to the social exclusion conceptual framework

Interviews and document review		Social exclusion conceptual framework: four relational dimensions			
Themes	Sub-themes	Social = Relationships and expressions of social solidarity and support	Economic = Economic issues that influence migrants' and refugees access to the NH	Cultural = Range from acceptance and respect of diverse values and ways of living to extreme views of stigma and discrimination	Political = Both formal rights embedded in legislation, policies and practices and the conditions in which rights are exercised e.g. access to healthcare
Disjuncture between international treaties or declarations, the South African Constitution, and national legislation and/or policies	• SA is signatory to United Nations Conventions/treaties on refugees • SA Constitution contains Bill of Rights (Section 27) • Provisions/entitlements for migrants in NHI Bill vague and potentially exclusionary • Variations in provincial policies, interpretation or implementation of national policies • Lack of/unclear policy guidelines on migrants or their rights	X			X
Under-investment, overburdened and dysfunctional public healthcare system	• Under-investment in public healthcare system • Resource constraints • Non-existent or dysfunctional systems • Ethical imperative of migrant inclusion	X	X		X
Complexity and/or contradictory nature of migrant access to healthcare	• Frontline health workers lack of knowledge on legal obligations • Identity documents as barrier to access • Misclassifications of migrants and refugees • Discretionary healthcare access to migrants • Discrimination by front-line health workers • Language differences as access barrier	X	X	X	X

(continued)

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Table 3. (Continued)

Interviews and document review		Social exclusion conceptual framework: four relational dimensions			
Themes	Sub-themes	Social = Relationships and expressions of social solidarity and support	Economic = Economic issues that influence migrants' and refugees access to the NH	Cultural = Range from acceptance and respect of diverse values and ways of living to extreme views of stigma and discrimination	Political = Both formal rights embedded in legislation, policies and practices and the conditions in which rights are exercised e.g. access to healthcare
Pathways and processes of social exclusion	• Societal values or attitudes • Social exclusionary behaviours of health policy actors • Denial of access or treatment of migrants and refugees • Language and exclusion • Fear of victimization and discrimination as a barrier to access	X	X	X	X
Migrant stereotypes, suspicions and discrimination	• Migrants and the spread of communicable disease • Migrants and overuse of South African public healthcare • Discrimination on the basis of limited resources • Migration detrimental to South African society	X	X	X	X

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KIs also highlighted a disjuncture, in the interpretation or implementation of national policies or in some cases, outright discriminatory, provincial policies or procedures. The KI from the UN organization reported on the circulation of 2013 'guidelines on foreign patients' in a provincial health department, distributed without the knowledge or approval of the National Department of Health. In line with this another KI who referred to these 2013 guidelines, said no one took ownership of these types of exclusionary health policies.

> *These [guidelines] go contrary to the Constitution and many other pledges and documents…One hospital was categorically refusing care to all refugees, asylum seekers…This kind of practice leads to exclusion* (key informant #4, UN)

One KI noted that the disjuncture or confusion arises due to a lack of a cohesive national legal or policy framework on migrants and refugees clearly outlining their entitlements, or rights to healthcare.

Theme 2: under-investment, overburdened and dysfunctionality of the public health system

Many KIs—inside and outside government—highlighted that the longstanding under-investment in the public health system exacerbates resource constraints. KIs indicated that migrants and refugees are seen as placing further strain on the resources in the public health system.

KIs from government reported that resource constraints were felt acutely in Gauteng, Limpopo and Mpumalanga provinces, and these contribute to healthcare challenges for migrants.

> *Those provinces feel severely constrained by a huge influx [of migrants], which is not budgeted for, in terms of resource allocation. This thing [migrants' healthcare access] is often a battle for scarce resources* (key informant #8, government).

The characterization of the public healthcare system as overburdened and largely dysfunctional was echoed by non-governmental KIs, noting that poor quality care is experienced by all users of the public health system, but the negative experiences of migrants and refugees are compounded because of their status.

> *If you're relying on the public health system, it's overburdened, it's overstretched, there's long waiting times and everyone experiences that challenge…non-nationals experience something quite specific around being foreign [and] manifests in issues around language, around the way people are treated* (key informant #15, academia)

According to two of the KIs from the academy, the perceived dysfunctionality is because mobility (migration), ethics and human rights are not considered explicitly in the public health system coupled with the lack of appropriate decision-making in the face of financial constraints.

> *What is the ethical response to [all] people with services and systems that are subject to financial constraints, quite significant constraints?* (key informant #14, academia)

> *The other issue, which we need to understand better, is the way in which decisions are made in a situation of limited resources* (key informant #15, academia)

In addition, KIs felt that the lack of information systems, insufficient costs or costing of service provision and 'obscure' decision-making contributes paradoxically to the under-investment in the public health system, which in turn contributes to the social exclusion of migrants and refugees.

One of the KIs from civil society stressed that there needs to do an assessment of South Africa's international and national obligations, inclusive of migrants and the resources needed to meet these obligations. This should then be followed by an assessment of resource availability, and development of strategies towards the progressive realization of these obligations.

> *There needs to an assessment of resources and the spending of resources, what resources are available, what resources are spent, as well as what our international and local obligations are, before cutting out a section of the population…. and not just say, can we tack on some services [for migrants]. They [migrants] can't be the bottom of the log* (key informant #2, civil society organisation).

Theme 3: access to the public health system is complex and contradictory

Although both the Constitution and the National Health Care Act stipulate the right of individuals to access essential healthcare (Republic of South Africa, 1996; National Department of Health, 2003), KIs pointed to a complex and at times, contradictory set of issues regarding migrants' healthcare access. They were of the opinion that access barriers were rooted in the failure of healthcare workers to implement legal service obligations to migrants and refugees, either due to a lack of knowledge on the obligations or outright discrimination.

KIs from civil society organizations put the responsibility of clear guidelines on migrants and refugees at the door of the national and/or provincial health authorities. The failure to provide clarity or policy guidelines leaves the interpretation up to frontline staff creating confusion among healthcare workers about the healthcare entitlements of migrants and refugees.

> *There is a lack of information on both sides…. Therefore, when they receive someone [migrant], immediately they see an outsider, a foreigner, they automatically tell the person to go back because they do not know how much should they offer that person at which level, with a document or not* (key informant #3, civil society organisation)

Barriers to access are exemplified by the over insistence on proof of identification prior to service. Several KIs noted that an identity document (ID) often determines healthcare access granted to migrants and refugees. The Immigration Act requires staff at healthcare facilities to determine the status of migrants presenting at facilities for healthcare before providing services and to report all undocumented migrants to the Department of Home Affairs (Department of Home Affairs, 2002).

> *People go to facilities and they are turned away simply because they didn't have a [ID] document* (key informant #3, civil society organisation)

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It's designed, in my view, to target foreign nationals and to exclude them (key informant #16, academia)

Another access barrier is the misclassification of refugees in terms of the hospital fee-paying system. Clerical staff classify users through a means test prior to the healthcare consultation. Migrants, in contrast to refugees, are expected to pay in terms of the fee schedule but frontline health workers do not understand the difference, hampering access. In some cases, the misclassification and subsequent denial of care is exacerbated by a lack of explanation to migrant patients.

That person comes with no cent and when they are sent away sometimes you find that they [healthcare worker] did not explain to them [migrant or refugee] to understand that it's a requirement [the fee] (key informant #3, civil society organisation)

These problems may be addressed when civil society organizations intervene to ensure the rightful classification of select migrants and refugees.

Our refugees and asylum seekers [have] been wrongly classified as private patients and have been made to pay just for a consultation close to R5000 [2020 exchange rates∼294 US dollars; R17=1$], which we have contested many times. It shows a fundamental problem in the whole system if we have to challenge individual cases for re-classification (key informant #1, civil society organisation)

The bureaucratic hurdles that create access barriers and exclude migrants and refugees intersect with rationing of resources and/or discrimination by frontline health workers.

The Bill of Rights in the Constitution states that 'No person may unfairly discriminate directly or indirectly against anyone…' (Republic of South Africa, 1996, p. 6). However, some KIs pointed out that health workers are members of the broader South African society, where discriminatory or xenophobic attitudes are prevalent.

The average South African is xenophobic, [and] does not like foreigners, feels [foreigners] are using resources. They shouldn't be [in] clinics. These hospitals are just replicating these other sentiments in society (key informant #13, academia)

Such discrimination goes against health professional codes of ethics and professionalism and results in health workers managing patients badly, as noted by a KI from government.

In addition, language differences may compromise the quality of care provided by healthcare workers and may influence adherence to treatment, keeping appointments or accessing care.

Then you also have language barriers that affect not only the care seeker, it's a factor affecting both sides, which hinder quality, access to quality public healthcare (key informant #4, UNHRC)

Theme 4: pathways and processes of social exclusion

Social exclusion manifests itself in the discriminatory and xenophobic attitudes and actions of some frontline health workers towards migrants and refugees. KIs from civil society and academia said the recurring incidents of xenophobic violence in South Africa illustrate a broader process of social exclusion. The discrimination is present in the labour markets and access to employment, membership of social groups, and the possession of the identity document [ID].

One KI pointed out that nurses might verbalize the narrative of politicians.

I found them [nurses] arguing with patients. 'Why are you here? Do you want special treatment?' I think that [expressed discrimination] comes across more because nurses have so much more contact [with patients]. They are in that one ward, 12 hours at a time. I find that nurses forget that a patient is a patient. If you look at the statement made by the MEC and the Minister of Health recently [in 2019], when we were criticized for the state of our hospitals. It was justified by them that we've got so many people from the outside that we're treating (key informant #5, government)

Another informant noted that some health workers do not hide their discriminatory views of migrants.

I think what is so incredible [for me] is how open people are. [They say] 'You are a makwerekwere [a derogatory term for a foreigner], what are you doing here, get out of my clinic' (key informant #13, academia)

These forms of discrimination also extend to treatment for migrants.

I've had cases of people being denied access to treatment, not because they don't have rights, but because they are not South Africans or did not belong here as many people would say, which is contrary to what the law says. There are cases of people who have been denied admission to beds because they are not South African. There are cases of people who have been treated or given some kind of treatment and told to go when ordinarily they should be admitted. There are people who have been denied [surgical] operations because they are not South African (key informant #1, civil society organisation)

However, the situation is more complex than denial of access or discriminatory attitudes. Health system constraints contribute to the feeling of frustration among healthcare workers, who may take this frustration out on patients, especially foreign patients. One KI highlighted language differences as a potential trigger accounting for challenging and frustrating interactions

Maybe you have one nurse that is going to attend 50 or 100 clients a day. They [nurses] are already overburdened. On top of that, someone comes and doesn't understand the [local] language, it creates a frustration, and the nurse can just say something [derogatory] out of frustration that's going to affect the [migrant] patient (key informant #9, government).

Furthermore, language differences may also serve as an identifier of migration status. While the accent of migrants,

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despite speaking English fluently, can exacerbate exclusionary behaviours by healthcare providers.

> *Language is an expression of culture. People are able to distinguish whether you're a foreigner or a South African by virtue of the language you speak. Language is an important part of social inclusion or social exclusion. Some refugees or immigrants cannot speak English or any South African language and as a result, our health providers marginalize them* (key informant #10, government)

In addition to language as an identifier, fear of victimization and discrimination can act as a barrier to access public healthcare services. Migrants and refugees may perceive being treated unfairly which sets the tone for their experiences at facilities. The knock-on effect is that migrants and refugees will take on the added expense and rather use private health services.

> *The refugee might already know that we shouldn't be going to that facility, which is the nearest one, because we won't be treated well there* (key informant #7, government)

> *They would rather save up money and go to a private GP than take their chances with the abuse they [might] get from the public service* (key informant #13, academia)

Theme 5: suspicions, stereotypes and discrimination

Some of the KIs highlighted that suspicions and stereotypes about migrants and refugees often overlay with discrimination and xenophobia resulting in healthcare access barriers. These stereotypes include misconceptions that migrants encourage the spread of communicable diseases, that they overuse South African public health services, as well as the detrimental effects of migrants and migration on the South African society.

The views on migrants and the spread of communicable diseases present both a stereotype, and a public health concern. This perpetuates barriers to access and, furthermore, prevents those migrants and refugees with communicable diseases from seeking treatment. The only way we are going to deal with communicable disease control is by including population mobility in our responses (key informant #15, academia)

KIs noted that there is also a perception among healthcare workers that migrants and refugees come to South Africa for maternal healthcare and have many children to qualify for government grants. While children born in South Africa do not automatically qualify for citizenship, the perception still perpetuates barriers to access.

Another narrative that emerged among KIs was the belief among South African society that migrants deplete already limited resources that should be allocated to South Africans. A KI from the academy highlighted that migrants and refugees are also perceived by citizens as detrimental to South African society. These sentiments echo the existing perceptions that migrants are 'stealing jobs' meant for South Africans.

> *We don't live in a society where immigration is viewed positively, so people believe the rhetoric that 'oh they're coming to get the services, they're coming to steal the jobs, they're coming to get healthcare'* (key informant #15, academia)

Discussion

In this qualitative study, we explored whether legislation, health policies and the actions of health policy actors facilitate UHC for migrants, or exacerbate exclusion, and reproduce inequalities and discrimination against migrants. We used the WHO definition of UHC that embodies the concepts of equity, quality and financial risk protection (WHO, 2019). Notwithstanding the contestations around the NHI in South Africa (Gilson, 2019; Zondi and Day, 2019), the 2019 NHI Bill is an important indicator for the intentions of the South African government to provide UHC for migrants and refugees.

Our findings suggest that paradoxically, legislation and policies in South Africa both facilitate and exclude healthcare for migrants. Despite a right-based and non-discriminatory Constitution and an enabling National Health Act, the Immigration Act and the 2019 NIH Bill make the legal status of migrants the most significant determinant of healthcare access (Republic of South Africa, 1996; Department of Home Affairs, 2002; National Department of Health, 2003; 2019). This disjuncture is exacerbated by the reported variations in content, interpretation and/or implementation of policies at the provincial level. Abbas *et al.* have highlighted the erratic and volatile nature of policies towards migrants in Europe and the USA that are unresponsive to their needs (Abbas *et al.*, 2018). Sargent has argued that access to healthcare for migrants is a product of [health] policies of entitlement or exclusion, reflecting the notion of 'deservingness' or the moral worth of migrants to quality health services (Sargent, 2012). Other studies also illustrate the influence of legal status on migrants' access to comprehensive health services (Hannigan *et al.*, 2016; Chiarenza *et al.*, 2019). Both WHO and the IOM have stated unequivocally that achieving the SDG target on UHC is dependent on meeting the health needs of migrants and refugees and ensuring that they have access to quality and affordable health services (International Organization for Migration (IOM), 2019). Although there is recognition of the mammoth task in achieving migrant-friendly, inclusive health systems that will ensure UHC, this aspirational goal also provides an opportunity to promote a more coherent and integrated approach to health and well-being, rather than vertical disease-specific interventions (International Organization for Migration (IOM), 2019; Abubakar and Zumla 2018; Abubakar *et al.*, 2018).

There was consensus among KIs regarding the resource constraints and under-investment in the public health sector. These in turn contribute to the perceived dysfunctionality of the public healthcare system, which affects the financial classification, quality of care and access for all patients. Other South African studies have demonstrated the under-investment, fault lines and burden of care in the public health sector (Rispel, 2016; South African Lancet National Commission, 2019; The Presidency, 2019; OXFAM South Africa, 2020). An OXFAM South Africa (2020) research study found a combination of neoliberal economic policies, insufficient investment in the health system and workforce, and poor implementation of existing legislation have created the perfect storm of inequities and fragility of the South African health system. Several initiatives are addressing the major diagnostic problems in South Africa's health system (The Presidency, 2019). However, most KIs reported the experiences of health system responsiveness were worse for migrant patients, who encountered a combination of

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structural, social, cultural and economic exclusion. Although the intersection of under-investment, resource constraints and dysfunctionality contribute to the exclusionary behaviour and actions of frontline health workers, this cannot condone the reported discrimination and stigma experienced by migrant patients.

In our study, the reported discrimination and stigma experienced by migrants included the request for IDs, financial misclassification, discretionary healthcare access, denial of treatment and sometimes name-calling and outright discrimination by frontline health workers. These are examples of what Crush and Tawodzera have termed 'medical xenophobia', or the 'negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job' (Crush and Tawodzera, 2011, p. 655). KIs from government pointed out that frontline health workers reflect the negative societal stereotypes and express political sentiments about migrants and migration. These negative stereotypes were also found in a 2017 study that examined post-apartheid narratives about 'foreigners', with African migrants blamed for all social ills in the country (Pineteh, 2017). Pineteh (2017) found African migrants are framed as the adversary blamed for all social ills in the country. White and colleagues found that 21.0% of the 277 health workers surveyed in public health facilities of a South African province reported that they had witnessed discrimination against migrants, while 22.6% reported differential treatment of migrant patients (White *et al.*, 2020a). Surprisingly, KIs from government did not condemn these incidents of discrimination that they relayed, even if the culprits did not represent the views of the majority of health workers or the South African public health system.

The review of migrants' access to healthcare services in the EU does not mention discrimination explicitly (Hannigan *et al.*, 2016). However, experiences from Thailand have shown the need for high-level political leadership to protect the human rights of migrants and principles of non-discrimination in accessing health services (Suphanchaimat *et al.*, 2016).

Our study findings suggest that civil society organizations played an important role, intervening and mediating access to care for migrants. Other studies have highlighted the role of civil society in advocating for the health rights of migrants (Ambrosini and Van der Leun, 2015; Orcutt *et al.*, 2020), or in ensuring quality UHC (Brolan *et al.*, 2017).

There are a few recommendations that arise from this study. First, evidence suggests that the removal of legal restrictions is an important prerequisite for UHC, even though it does not guarantee equitable, quality healthcare access for migrants (Abbas *et al.*, 2018; Legido-Quigley *et al.*, 2019). Although Germany is a high-income country with a different context to South Africa, a study that examined the effects of restricted access and two major policy reforms on incident health expenditures for asylum seekers and refugees found the cost of exclusion was much higher (Bozorgmehr and Razum, 2015). This led to both delayed care, and increased costs of care (Bozorgmehr and Razum, 2015). In South Africa, the NHI Bill both restricts healthcare access for migrants and appears to be unconstitutional. Several individuals and civil society organizations previously made submissions or inputs on the NHI and migrant exclusion. Our study findings also suggest the need for revisions to the NHI Bill to ensure at the health system is responsive to the needs of migrants and refugees. Such revisions would also be in line with the South African Constitution, and the draft migration policy framework of the African Union that recommends UHC for all migrants (African Union, 2017). In addition, revisions to the NHI Bill will ensure that the government meets its international obligations in respecting and promoting the human rights of migrants and refugees (International Labour Office (ILO) *et al.*, 2001; International Organization for Migration (IOM), 2019).

Several scholars have shown that legislation on its own cannot bring about effective change (Adjai and Lazaridis, 2014; Alfaro-Velcamp, 2017; Legido-Quigley *et al.*, 2019; OXFAM South Africa, 2020). Hence, our second recommendation relates to the importance of addressing the resource constraints and under-investment in the South African public healthcare system. Although improving the performance of the health system is a key government priority (The Presidency, 2019), leadership and implementation remain problematic. Investment in health and in the health system will facilitate quality UHC for all, including for migrants and refugees (South African Lancet National Commission, 2019; Oxfam South Africa, 2020).

The KIs in our study reported various incidents of medical xenophobia, which require a conscious and comprehensive effort to address. Scholars have argued that the pervasive xenophobia in South Africa requires multi-prong strategies at individual-, organizational- and state-level strategies (Adjai and Lazaridis, 2014; Tella, 2016). Our third recommendation relates to the responsibility of senior public servants and health managers to ensure health professionals uphold their professional codes of conduct. Health professionals are bound by codes or ethics, and they pledge to practice with conscience, dignity and without discrimination and to advocate on behalf of vulnerable and disadvantaged patients, regardless of gender, political persuasion and nationality (Gallagher and Little, 2017; Meier *et al.*, 2018; Amon and Friedman, 2020). Drawing on the Rollback Xenophobia campaign, a broad coalition of UN, government, civil society organizations, health professions councils and representative organizations is needed to prevent and combat medical xenophobia (National Consortium on Refugee Affairs (NCRA) *et al.*, 1998). Such a campaign should focus on human rights, zero tolerance towards xenophobia and other types of discrimination, mutual respect and the importance of Pan-Africanism (Tella, 2016). The campaign should be complemented by continuing professional development programmes on human rights, ethical dilemmas in the health system and its responsiveness. Furthermore, user-friendly clear guidelines should be developed that include the rights and responsibilities of healthcare providers, migrants and refugees, and healthcare entitlements. The coalition should ensure the media plays a role in condemning xenophobic and discriminatory attitudes and actions.

The relatively small number of KIs limited our study. KIs from civil society organizations were primarily Gauteng based, and only one was from a UN organization. Hence, the findings may not be representative of other provinces in South Africa. However, we reached data saturation after 10 interviews. The findings provide a glimpse of the experiences of migrants in the public health sector, as educated migrants in higher socioeconomic groups are more likely to have private health insurance and would not utilize the public

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health sector. Although six KIs confirmed their views in 2020, the interviews were conducted over a 5-year period, and this is a potential limitation.

Nonetheless, our study has several strengths. First, the SEKN social exclusion model is a useful, analytical framework to explore whether policies facilitate UHC or exacerbate exclusion for migrants. A methodological strength is the combination of KIIs and a document review to explore whether healthcare policies facilitate UHC or exacerbate exclusion for migrants in South Africa. We obtained rich narratives on UHC and migrants in South Africa, which adds to the discourse on a migrant-friendly health system in South Africa as well as the global discourse on UHC for migrants and refugees (Vearey *et al.*, 2017).

Future research should explore the evolution of the NHI legislation and policy development on migrants and refugees using the health component of the IOM's Migration Integration Policy Index (Abbas *et al.*, 2018). The health indicators cover four dimensions: entitlement to health services, policies to facilitate healthcare access, responsive health services and measures to achieve change (Abbas *et al.*, 2018). Another potential research area could be a comparative analysis of legislation and policies on migrants and UHC in South Africa and other countries with a similar level of income. Such research could also explore the reasons for the contradictions in legislation, policies and actual implementation, as well as the actors, processes and power dynamics that contribute to these contradictions. The important role that civil society plays in mediating access for migrants in South Africa should be also be investigated. Last, further research could compare the experiences of migrants and refugees with those of other vulnerable groups, whether by geography (e.g. rural, informal settlements), health condition (HIV, disability) and/or sexual preferences (LGBTIQ+).

Conclusion

Health legislation and policies shape healthcare coverage and ultimately, access to and utilization of healthcare services for migrants in South Africa. Our study highlighted the contradictions that exist between an enabling Constitution and National Health Care Act and an exclusionary Immigration Act and NHI Bill. Our study underscores the need for revisions to the NHI Bill to ensure an inclusive healthcare system for all people, regardless of nationality. However, legislative changes need to be accompanied by investment in the South African health system, strategies to improve its performance, value-based leadership and management of the health system, and a broad coalition that ensures the prevention and mitigation of medical xenophobia.

Data availability

The data underlying this article will be shared on reasonable request to the corresponding author.

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Ethical approval

The Human Research Ethics Committee (Medical) Ethics of the authors' institution provided approval for this study (#:M140848).

Conflict of interest statement

The authors declare no conflict of interest.

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CHAPTER 5: CONTESTED AND NERVOUS SPACES: EXPLORING THE ENVIRONMENT OF HEALTH CARE PROVISION FOR MIGRANTS IN THE GAUTENG PROVINCEOF SOUTH AFRICA

Abstract

Background

Notwithstanding the global goal of universal health coverage (UHC), and the notion of "migrant-sensitive" health systems, there is limited health care access or the exclusion of migrants from national health systems. South Africa has a rights-based constitution, but there is an inability or a failure of the health system to recognise and address the health needs of migrants.

Objective

The aim of this study was to explore the intersection of the environment of health care provision for migrants and the everyday practices and behaviours of health workers and patients in the Gauteng Province of South Africa.

Methods

The conceptual frameworks of health systems responsiveness (HSR) and social exclusion informed this ethnographic study at 13 health care facilities in Gauteng province. We developed an observation guide to explore the environment, behaviours and practices of health workers and patients, and the intersection of culture and environment and its influence on healthcare provision to patients, especially migrants. Following ethics approval and informed consent, we conducted the ethnographic study between April 2018 and December 2018 and observed the facilities for 234 person-days. We concentrated the observations on entry points, reception, registration and waiting areas and the exit points of the 13 health facilities. We used thematic analysis to analyse the consolidated information from the observations and field notes.

Results

We identified four overlapping themes of context, environment and spaces; patients, patience, agency and behaviour; health workers, ethics and street level bureaucrats; and variations in and the ambivalence of health care provision. Busy, frantic or nervous spaces,

and contestations between patients and health workers, and among health workers formed part of the social and cultural environment of health care provision. The presence of migrant patients during busy periods served as a detonator for rude or discriminatory remarks, exacerbated by staff shortages and language barriers. Simultaneously, migrants exercised their agency by rebutting or confronting rude health workers. We also observed encouraging examples of kindness, caring and professionalism of health workers in the selected health facilities.

Conclusion: The study has implications for achieving a migrant-sensitive health system in South Africa.

Keywords: Health systems responsiveness; social exclusion; migrants; health workers; South Africa

Introduction

> On the first day of fieldwork in April 2018, I arrived at a small primary health care clinic situated in a Johannesburg suburb. The security guard opened the gate, and allowed me to park in the staff-only designated area. Already this action distinguished me from the patients at the clinic. My plan was to blend in, and to do it in a manner that did not influence the interactions between health workers and patients. I was also careful to dress in a way that does not draw attention to me. At the time of my arrival (7 am), there were many patients already seated in the main reception and the spill over area. It was easy to see migrant patients, from the way they were dressed and the language they spoke. I walked through the small reception area to the facility manager's office. My contact person at the facility was a professional nurse [at least four years of training]. We met before as I had been to the clinic on a previous visit to ask for permission to conduct the study. She was curt. I was mindful of my presence there and almost felt out of place. I reminded her of the research study, and that two fieldworkers would join me. I promised that we would be unobtrusive. She walked with me into the main reception area, filled to capacity with patients: men, women, children, old and young. She turned to a woman with a child on her lap and addressed her in isiZulu [one of South Africa's official, indigenous languages]. When the woman replied in English, the health provider told her "I'm going to deport you" and laughed (Janine White's research field notes, 16 April 2018)

This experience on the first day of fieldwork of the doctoral research study illustrates how language as an identifier [of migrants], and the power of a health worker to mediate health care access, combined to stigmatise migrant patients and highlight their vulnerability when utilising public health care services in South Africa. This is despite the global discourse on universal health coverage (UHC), which combines the principles of equity, need and financial risk protection (2, 23, 140, 160, 161). Linked to the discourse on UHC is the notion of "migrant-sensitive" health systems (47, 162-167). Migrant-sensitive health systems are defined as the conscious and systematic incorporation of "the needs of migrants into all aspects of health service financing, policy, planning, implementation, and evaluation" (167 ,p.3).

Notwithstanding the development and/or implementation of encouraging programmes to mainstream migrant health needs into health systems (167), several authors in high-income countries have highlighted migrants' exclusion from national health systems or their limited access to health services (168-175).

Researchers in low-and middle-income countries (LMICs) have also highlighted the contradictions between the notion of migrant-sensitive health systems and their exclusion or unequal treatment. A comparative study in Argentina, Chile and Costa Rica found that existing migration and social policies and the nature of the health care system in each country contributed to the variations in health care for migrants (176). In Malaysia, a study on UHC and health care access for migrants documented numerous barriers. These included financial constraints, the need for legal documents, language barriers, discrimination and xenophobia, physical inaccessibility and the exclusion of undocumented migrants (177). In Thailand, an evaluation of cultural mediation and language interpretation services implemented since 2003 as part of 'migrant-friendly health services', found that insufficient budgets for employment and training, diverse training curricula, and lack of legal provisions threatened the sustainability of these services (178).

South Africa has a rights-based Constitution (31), but scholars have argued that there is a failure or an inability of the health system to recognise and address the health needs of migrants (47, 68). Research studies have illustrated the disjuncture between migration and health policies, and migrants' experiences of discrimination, social exclusion and medical xenophobia when utilising public health services (59, 61, 63, 107, 142). At the same time, Vanyoro (2019) has highlighted the diverse experiences of migrants in the South African public health system, that are contrary to the dominant narrative of healthcare workers practising indiscriminate medical xenophobia (135).

Quasada (2012) has argued that the disjuncture between national health goals and actual practice and the social exclusion experiences of migrants could partly be explained by the localised nature of health care delivery at a clinic or hospital (179). The national authorities have little control over the uneven or unequal treatment at individual health facilities, as such treatment is influenced by the public discourse on migrants, healthcare workers' discretion, their perceptions of the deservingness or moral worth of migrants to access services, and/or local resource constraints (179). Hence, some scholars have focused on local institutions, their responsiveness to the needs of migrants, the environment of care provision, and/or the behaviors of health policy actors (135, 141, 168, 180-183).

Health systems responsiveness (HSR) is a measure of the performance of the health system and its ability to meet the expectations of individuals when using health services (6). The World Health Survey has used primarily a quantitative approach to measure HSR, focusing on eight domains of dignity, autonomy to participate in health-related decisions, confidentiality, prompt attention, adequate quality of care or basic amenities, communication, access to social support networks, and choice of healthcare worker (7 ,p.5). Consequently, there is a substantial literature on HSR and scores obtained in surveys across diverse country settings (184-187). Although the measurable constructs of HSR provide valuable information, research has found that there are systematic variations in the HSR scores according to socio-demographic characteristics and across country settings (188). Furthermore, quantitative scores cannot explain the nuances of HSR at the level of local health facilities and the influence of different physical, social and cultural environments (189, 190).

Notwithstanding the controversial evolution and development of the field of ethnography (191), social scientists have underscored the potential and benefits of ethnographic studies in enhancing our knowledge and understanding on migration and the rich history of migrants (192-196). There is a substantial literature on ethnographic research in health and health care (197-199), and the intricacies and dynamics of health care access for migrants (168, 170-172, 174, 175, 194, 200-202). However, the majority of these studies are in high-income countries.

In South Africa, there is a dearth of ethnographic studies on HSR and migrants in public health facilities. The aim of this study was to explore the environment of health care provision for migrants and the everyday practices and behaviours of health workers and patients at a selection of clinics and hospitals in the Gauteng Province of South Africa. Environment refers to the physical, social and cultural aspects of health care provision (73, 110). This paper is part of a larger doctoral research study that examines HSR, social exclusion, migrants and health care utilisation in the public health facilities of a South African province.

Methodology

Conceptual framework

This study connects and adapts the distinct concepts of HSR (74) and social exclusion (8) to observe the intersection between the everyday behaviours and practices of health workers and patients and the environment of health care provision in public health facilities.

HSR is one of the key goals of a health system (203). Notwithstanding the existence of a quantitative HSR construct, Mirzoev and Kane (2017) highlighted the lack of a comprehensive conceptual framework for HSR (74). Consequently, their proposed HSR framework positions people's experiences of dignified treatment, autonomy, confidentiality, prompt attention, access to networks, quality of amenities, choice of provider, and trust at the core of the framework (74 ,p.8). The framework takes into account the determinants of people's experiences of HSR both from the perspective of the health system (e.g. processes and policy actors such as health workers and managers) and the health service users (e.g. their initial expectations) (74). The HSR conceptual framework recognizes that health policy actors, health service delivery processes, and organizational arrangements shape the experiences of health service users or patients (74). In addition, there is a broader political and socio-cultural context which intersects with the health system and with people (74). This HSR conceptual framework resonates with the definition of social exclusion as a dynamic, relational concept in health system, the centrality of people and power relationships, and the intersections of these with cultural, economic, political and social dimensions (8).

Both the HSR and social exclusion conceptual frameworks informed the ethnographic study at 13 health facilities in Gauteng Province(8, 74). In the study, we observed five of the eight core patient experiences of dignified treatment, autonomy, confidentiality, prompt attention, and quality of amenities, as it was neither practical nor possible to observe access to network, choice of provider and trust (74). We also observed the health care delivery processes, behaviours (e.g. the exertion of negative or unequal power), communication, and interactions between and among patients and health workers.

Study setting

The ethnographic study was conducted at 13 health care facilities in the Gauteng Province of South Africa. The rationale for, and selection of, the 13 facilities have been described previously (141, 142). Table 1 provides a brief description of the 13 health facilities.

Table 1: Brief overview of study setting

Type of facility	Brief description of selected health facility (HF)
Primary health care (PHC) clinic (n=2)-the first level of the formal health care system, providing a comprehensive range of ambulatory care services such as immunisation, family planning, antenatal care, and treatment of common diseases e.g. tuberculosis, HIV & AIDS. These PHC clinics operate Monday to Friday for 8 or 12 hours a day	**HF1**: A PHC clinic, under the auspices of local government, located in the eastern part of the City of Johannesburg. **HF2**: A PHC clinic under the auspices of the Gauteng provincial government, located in the north-eastern part of the City of Ekurhuleni.
Community health centre (CHC) (n=2). A CHC is also part of the first level of the health care system. In addition to services offered by a PHC clinic, a CHC offers 24- hour maternity services provided by midwives, emergency services. Some larger centres have a short stay ward for observation. A CHC operates 7 days a week.	**HF3**: Very large CHC, situated in the inner City of Johannesburg. **HF4:** Large CHC, situated on the outskirts of the City of Tshwane.
District hospital (n=2): Provides level 1 in-patient services, generalist doctors, as well as outpatient and casualty services. District hospitals operate 24 hours a day, 7 days a week, and are the first level of referral for PHC clinics and CHCs.	**HF5**: A 300 bed district hospital, located in the City of Ekurhuleni, in the eastern part of Gauteng Province. **HF6:** A 180 bed district hospital, located in western part of the province, in the West Rand District Municipality
Regional hospital (n=2): Provides level 2, internal medicine, surgery, paediatrics, and obstetrics and gynaecology specialist services. Regional hospitals operate 24 hours a day, 7	**HF7**: A small 300 bed regional hospital, located in the south-eastern part of Gauteng Province.

Type of facility	Brief description of selected health facility (HF)
days a week, and serve as referral facilities for PHC clinics, CHCs and district hospitals.	**HF8:** A large 821 bed regional hospital located in eastern Gauteng.
Regional tertiary hospital (n=3): In addition to the four specialties of internal medicine, surgery, paediatrics, obstetrics and gynaecology, these hospitals also provide specialist tertiary services such as renal dialysis and orthopaedics. These regional tertiary hospitals also serve as both referral facilities and health professional teaching facilities. These hospitals also operate 24 hours a day, 7 days a week.	**HF9:** A 350 bed regional tertiary hospital, in the western part of the City of Johannesburg providing specialised services to women and children only. **HF10:** A 700 bed regional tertiary hospital in the western part of the City of Johannesburg providing specialised services to adults only, excluding obstetrics and gynaecology **HF11**: A regional tertiary hospital with more than 1000 beds located in the western part of the City of Tshwane.
Central hospital **(n=2): C**onsidered as national assets, providing highly specialised tertiary and quaternary services. These hospitals service as referral facilities for other levels of care in Gauteng Province, and for certain neigbouring provinces. The central hospitals also serve as health professionals' teaching platforms.	**HF12**: A central hospital, located in the south-west of the City of Johannesburg, with more than 3000 beds. **HF13:** An 832-bed central hospital, located in the centre of the City of Tshwane.

Ethnographic observation guide

Drawing on the HSR and social exclusion conceptual frameworks (8, 74), we developed an ethnographic observation guide to answer the following research questions: Firstly, what is the environment (physical, social and cultural) of health care provision at each clinic or hospital? Secondly, what are the behaviours and practices of health workers and patients (especially migrant patients) i.e. the culture, in each health facility? Thirdly, how does the culture and environment intersect, and how does it affect health care provision to patients, but migrant patients specifically?

The physical environment encompassed observation of the size of the waiting room, sufficient seating for patients, the availability of drinking water, and the cleanliness of the health

facilities. The social and cultural environment captured the behaviours of patients and health workers; and the atmosphere of the environment (using concepts of tension and busyness). In this study, health workers refer to any staff member who contributes to health care provision, whether directly (such as nurses and doctors), or indirectly (such as clerks, cleaners, security personnel) (75). We use the term health care provider when the person is a trained health professional such a nurse or doctor. In addition to the more structured items in the guide, we also captured public conversations or comments made to the researchers. Table 2 shows the observation guide for the study, and its linkages to the HSR and social exclusion conceptual frameworks.

Table 2: Observation guide

Conceptual framework	Research question	Observation guide
HSR - quality of amenities	What is the physical environment of health care provision at each clinic or hospital?	• What is the size of the waiting room? • Is there seating for patients e.g. chairs? • Are there enough chairs or sufficient seating? • Is there drinking water available? • Is the waiting room and/or health facility clean?
HSR - dignified treatment, processes, actors	What is the social and cultural environment of care provision? What are the interactions between and among health workers and patients?	• Who is sitting (men, women, South Africans, non-South Africans, old, young, pregnant?)? • Who is standing? • Are people treated with respect? • Are there obvious exclusionary practices e.g. labelling, name-calling?
HSR – prompt attention, processes, actors		• Are sick people sick attended to? • Which categories of health workers are visible in the facility? What are they doing or saying?
HSR-autonomy, confidentiality, processes, power relations, social exclusion		• Are questions asked in a respectful manner? • Are people treated in privacy? • What is the atmosphere in the waiting room or in the health facility (calm, tense, busy, frantic)? • What are the public conversations or comments in the waiting areas? • Are there obvious exclusionary practices e.g. labelling, name-calling?

Preparation for data collection

The principal researcher (JW) provided overall leadership for the study. The principal researcher (PR) visited each health facility prior to data collection and had a meeting with the chief executive officer of the hospital, or the facility manager of a clinic or CHC. During the meeting information on the study, the ethical approval, and study permission from provincial or local government were provided. The PR informed the relevant manager that three, randomly selected days would be spent at each facility, and in the case of 24-hour facilities such as hospitals and CHCs, one of those days would be on the weekend. Following the meeting, the PR developed a detailed schedule for data collection, which took into account the distance between facilities, and from the university. The PR sent the relevant schedule to each health facility manager, and ensured that the managers were aware of the dates for data collection.

Given the size of the doctoral research study with four distinct components, the PR recruited five additional fieldworkers, three of them from other African countries (Ghana and Zimbabwe). All the fieldworkers completed post-secondary education, and were familiar with fieldwork in health care settings. Prior to fieldwork, the PR developed a detailed procedure manual and facilitated a one-day training workshop. The workshop covered the aims of the study, ethical conduct, support with data collection, potential fieldwork challenges (e.g. dealing with difficult staff, refusal of study participants), and management of these challenges. The training workshop was complemented with role-plays with different scenarios, peer feedback, a writing exercise for field notes, and piloting of the survey tools at a health facility not part of the main study. The PR also ensured that all fieldworkers were supervised and supported during actual data collection. Each fieldworker had the mobile phone number of the PR.

Data collection

The data was collected between April 2018 and December 2018. At each facility, the PR and fieldwork team completed the observation guide for every fieldwork day independently. Each fieldworker also took detailed notes, and recorded the information in field diaries. The team focused the observations on entry points, reception, registration and waiting areas as well as the exit points of the health facilities. The total observation period at the 13 facilities was 234

person-days. At the end of the data collection period, observation guides and fieldwork notes were consolidated.

Analysis

The PR typed the completed observation guide and fieldwork notes, removed all facility identifiers, and allocated each facility a unique number. The observation guides and field-notes were analysed using thematic analysis (204).

The first step in the analysis was to read the consolidated information for each health facility without any preconceived notions or classification. We then examined the information in light of the study's research questions (Table 2).

The PR and an additional three researchers (two experienced qualitative researchers with health system experience and the doctoral supervisor) participated in the development of codes by reading the consolidated information for all 13 health facilities independently, thereby ensuring reliability and establishing intercoder agreement. Once the initial analysis was completed, the team met to discuss the independent codes, cluster these codes into themes and sub-themes and reach agreement on these (Table 3).

Ethical considerations

The Human Ethics Research Committee (HREC) Medical of the University of the Witwatersrand in Johannesburg, South Africa provided ethical approval for the study (#: M170988). Permission to access facilities and conduct the fieldwork was obtained from the Gauteng Department of Health (NHRD reference #: GP_201804_019), and the City of Johannesburg municipality.

The study was guided by the principles contained in the Singapore Statement on Research Integrity (153), and all ethical procedures were adhered to. An identifier was assigned to each health care facility to ensure anonymity and confidentiality. The health workers or health service users (patients) referred to in the observation guides or field notes remain anonymous. The data are kept on the PR's password-protected computer.

Results

Although overlapping, we identified four themes from our ethnographic research: (1) context, environment and spaces; (2) patients, patience, agency and behavior; (3) health workers, ethics and street level bureaucrats; and (4) variations in and ambivalence of health care provision (Table 3). The description of each theme is below the table.

Table 3: Themes from ethnographic observations at health facilities

Theme	Sub-themes
Health care context, environment and spaces	• Variations in cleanliness. • Littering in health facilities. • Variations in availability of basic amenities (e.g. water, tissue paper. • Insufficient seating. • Overcrowding. • Insufficient number of consultation rooms. • Lack of privacy. • Tense or nervous atmosphere.
Patients, patience and agency	• Large number of patients. • Diversity in number of migrants at different facilities. • Expressed dissatisfaction or anger because of delays in, or lack of care provision. • Leaving facilities before consultation. • Refusal of urgent medical treatment. • Confronting rude or unacceptable health worker behaviour.
Health workers, ethics and street level bureaucrats	• Caring and empathy. • Staff shortages. • Perceived lack of urgency for emergencies. • Language barriers. • Contestations among health workers. • Disrespectful and unprofessional behaviour. • Expressed stereotypes or xenophobic views about migrants.
Variations and ambivalence in health care provision	• Variations in waiting times. • Structured and well-organised systems of triage or waiting. • Disrespectful or patronising verbal communication. • Denial of care because of lack of documentation. • Deservingness of migrants to utilise public health facilities.

Theme 1: Health care context, environment and public spaces

This theme comprises the physical environment and the public spaces of health care provision and interactions among health workers and patients. We observed that the 13 health facilities functioned as vibrant social spaces. Vendors and entrepreneurs sold food or other items to patients who were a captive audience as they waited their turns for health care consultations. Health service users or patients connected with each other, and in some instances shared parenting advice.

Across the 13 health facilities, we observed variations in the cleanliness and the availability of basic amenities (e.g. drinking water, tissue paper). Drinking water was mostly available. Each observation day, all the 13 facilities commenced with a clean and relatively litter-free environment. However, the cleanliness of the waiting areas and public bathrooms changed throughout the day, influenced by the [in] activities of the cleaners and littering by patients. We observed appeals from health care providers to patients in waiting areas to assist their work by refraining from littering and using the trash bins in the waiting areas. In some instances, the behaviour of health workers also influenced the cleanliness of facilities. At HF8, we observed that used intravenous tubing was discarded into the bin of the public bathroom, instead of the medical waste container. At five of the health facilities (HF3, HF5, HF8, HF10, HF11), we observed a lack of tissue paper in the public bathrooms, as the day progressed.

The age of and infrastructure at the 13 facilities determined the adequacy of waiting areas and seating arrangements. At the PHC clinics, the infrastructure was limited, with an insufficient number of consultation rooms. At HF 1 and HF2, the health care providers were obliged to share consultation rooms on busy days. This resulted in a lack of privacy and breach of confidentiality during patient examination. During our data collection period, we observed a health care provider taking a blood pressure of a female patient in the reception or waiting area of HF1, in full view of those present. As the older female patient had to undress partially for the cuff of the sphygmomanometer, her right to privacy was violated. Similarly, the scale for weighing patients was placed at the door leading into the main reception area, thus compromising confidentiality.

On busy days, which varied depending on the type of facility, there were large numbers of patients seeking care, contributing to overcrowding and noise in the waiting areas. Such

overcrowding in turn influenced the atmosphere in the health facility. We observed both nervous patients, often unsure what time their consultation turn would be, and tense or irritable health care providers, when faced with a sea of people in the waiting room. The atmosphere was also influenced by the location of the outpatient department in the health facility. Those outpatient departments close to emergency (casualty) departments in hospitals appeared chaotic, especially when seriously ill or injured individuals arrived. At HF10, we observed an incident when a mentally ill man's condition deteriorated while waiting in the outpatient department. This necessitated the health care providers to obtain the assistance of security personnel to restrain the individual. The presence of migrant patients during the very busy periods sadly served as a detonator for rude or discriminatory remarks, such as observed at HF1, HF3, HF4 and HF9. In contrast, the spaces in health facilities appeared quiet and calm when there were fewer patients.

Theme 2: Patients, patience and agency

We observed that the selected health facilities were busy, with large numbers of individuals seeking health care. Notwithstanding the common narrative from many health facility managers that "foreigners" constituted the majority of patients, our observations revealed great diversity. In some facilities (HF1, HF3, HF4, and HF9), the research team recruited a large number of migrant patients on the three randomly selected fieldwork days.

During our fieldwork, many patients expressed dissatisfaction or anger because of delays in, or lack of care provision. At HF1, a female migrant, complained that she had been at the clinic for several hours. She decided to leave to go to work, without consulting with a health care provider, and indicated that she would try to return to the clinic the following week. At the same HF1, another woman left with her sick child before the health care consultation because of lack of attention by the health care providers, who were allegedly "just sitting".

At HF5, we witnessed a patient's refusal of urgent medical treatment, despite the explanation and pleas from health care providers. The health care providers explained to a male, South African patient and his fiancé the seriousness of his medical condition and the need for transfer to and admission in a central hospital. The man's fiancé was adamant that the pain medication was sufficient and that he could go to the central hospital the next day. The health care provider explained that she would order an ambulance because of the seriousness of the

condition, but also indicated that she could not force them to stay. Within 20 minutes, the ambulance arrived, but the couple could not be found anywhere.

At some facilities, we observed that patients exercised agency by confronting rude or unacceptable behaviour. At HF7, a female migrant patient rebutted a health care provider who told her that she was not sick because she looked beautiful. At HF 10, another female migrant patient confronted a nurse in the triage section who scolded her for coming to the hospital dressed in a nightgown.

Theme 3: Health workers, ethics and street level bureaucrats

Our observations revealed that the interactions between health care providers and patients ranged from professionalism, compassion and empathy to disrespectful and unprofessional behaviour, and in some instances, health workers made outright discriminatory comments about migrant patients.

At HF4, the kind, professional and compassionate behaviour of a nurse was striking. She regularly monitored the parents and their children in the waiting area, encouraging parents to speak up if their children needed urgent attention. In HF2, nurses and other staff members performed their respective duties, and the interaction was cordial. In many of the health facilities, we observed cleaners sweeping or polishing floors to ensure a hygienic environment.

The behaviour of health care providers, and their interactions with patients were influenced by staff shortages and resource availability. We witnessed a haunting incident at HF7 in the emergency department on a busy Sunday morning during fieldwork. Among the many patients with serious trauma and injuries waiting for medical attention, a family member wheeled an elderly, frail man into the emergency room. Later that morning, a young female doctor came to check on him, and discovered a weak or absent pulse. This set in motion frantic action by the doctor and her colleagues, of pushing the elderly man into the resuscitation area, and asking everyone to leave the area, including the research team. We do not know what happened to the elderly man.

Language barriers challenged both health care providers and patients in different ways. At HF9, a Zimbabwean migrant patient explained hysterically in isiNdebele (an indigenous

Zimbabwean language) that she was having a miscarriage. The nurses could not understand the woman, but were seemingly unperturbed by her body language and screams that suggested an emergency. They attended to her as if a routine case. Again, we do not know what happened to this woman. At the same HF9, we observed a migrant patient struggling to explain her symptoms, resulting in the nurses getting irritated and shouting at her.

However, even when the same language is spoken, barriers exist between the use of technical language or terms, and the comprehension of patients. At HF7, nurses tried to teach female patients about condom use, but the nurses got impatient and started shouting when the patients did not engage with them during the demonstration.

In some facilities, the tensions, insufficient teamwork or lack of collaboration boiled over, exacerbated by the hierarchical nature of the health care system. At HF1, a clerk informed the nurses in the tearoom about an estimated 40 patients in the waiting room. He threatened to escalate the lack of attention to patients to the PHC clinic facility manager. One of the nurses reprimanded the clerk and asked him, "*Who do you think you are*".

Our observations demonstrated some health care providers' disrespect, and prejudicial views about migrant patients. At both HF2 and HF11, some health care providers told the researchers that migrant patients demanded a three months' supply of medicines with the intention of selling the medicines or sending it to family and friends living in their home countries. They also alleged that migrants obtained South African identity documents fraudulently in order to access health services.

Theme 4: Variations and ambivalence in health care provision

Waiting times in the health care facilities varied a great deal, influenced by the number of health workers at a facility relative to patient numbers and the internal hospital systems for managing queues. At HF5, we observed an excellent example of structured and automated patient queueing system. There were clearly demarcated areas for the provision of different health care services. Patients were able to hear when their number was called and to see the designated consultation room in the hospital. In contrast, at some of the other clinics and hospitals (HF3, HF8, HF9, HF10, HF11), we noticed that the poor organisation of patient queues and the lack of information about the different queues. This in turn led to long waiting

times. In some instances, patients found themselves in the wrong queue, which further increased their waiting time.

We observed that verbal communication could both provide useful information and be patronising and potentially disrespectful at the same time. At HF1, a nurse who was responsible for childhood vaccination, reminded the parents of children about the specific clinic days designated for vaccination. She addressed the patients in the waiting area and asked them why they were throwing litter on the floor when there was a dustbin for trash. Lastly, the nurse talked to the patients about nutrition and feeding of their children. She stated publicly that:

> *"Young ladies are lazy to make soft porridge. Yoghurt is a snack - if you cannot cook for the baby don't make the baby. I love babies, when I fight with you, I'm fighting for the baby".*

At the same facility, the general assistant responsible for maintenance shouted at a migrant woman because her son was playing in the parking space. An argument ensued, and the general assistant told the woman that she should "go home". At HF9, a health care provider remarked to the migrant pregnant women in the waiting room that "*all of you come here* [to South Africa] *when you have to give birth*".

At HF13, we observed that a migrant patient was turned away because of lack of documentation. The attending nurse explained that emergency cases are not required to produce documentation, but that documentation is required when the individuals returned for a follow-up appointment.

Similar to the incident described in the introductory paragraph, we observed another example of a health care provider's judgement about the deservingness of migrants to utilise public health services. A migrant woman with a sick child was kept waiting for 30 minutes for the consultation at HF4, although there was no one in the emergency section of the facility at 5pm in the afternoon. The health worker at reception asked the woman why she waited the whole day to come to the facility. The migrant patient replied that she was working and could only bring her child for a consultation at that time. Eventually, the woman was called into the consultation room when the health care provider considered it appropriate to see her.

Discussion

In this ethnographic study, we combined the lens of HSR and social exclusion to explore the intersection of the environment in which care is delivered for migrants and the everyday practices and behaviours of health workers and patients.

We found that ageing and unfit-for-purpose health facility infrastructure contributed to sub-optimal patient experiences of dignified treatment and confidentiality. The violation of patients' privacy and confidentiality was stark at the PHC clinics, where nurses shared consultation rooms and where there was no space for patient screening and/or weight measurement. Although a different context, a systematic review of migrant women's experiences of pregnancy, childbirth and maternity care in European countries found that women associated quality care with health facilities that promoted privacy (205). In South Africa, the infrastructural constraints at PHC level have led to substantial government investment in the Ideal Clinic Realisation and Maintenance Programme to improve the quality of health care (206). Although the building or addition of new rooms to a clinic is outside the remit of an individual PHC facility manager, a core responsibility is to ensure the provision of holistic and comprehensive care to patients (207). Hence, it should be possible to find a way to re-organise services to ensure greater privacy and confidentiality, especially during busy periods.

Our study found that HSR was influenced by variations in facility cleanliness and the availability of basic amenities that intersected with the negative behaviours and actions of patients and health workers. Although cleanliness appears straightforward, patients who littered, lax cleaning staff, or inappropriate disposal of medical waste made it difficult to maintain health facility hygiene, a core element of HSR. A 2017 HSR study in Ethiopian health facilities found that the domain of basic amenities obtained the lowest scores and did not meet patient expectations (185). In South Africa, cleanliness of health facilities remains one of the priority areas for inspection by the Office of Health Standards Compliance (71). The 2018/19 inspection report confirms our ethnographic observations regarding cleanliness, as hospitals and CHCs obtained average cleanliness scores of 68% and 65% respectively, while clinics scored only 48% (71). Our ethnographic study suggests that cleanliness and

improvements of basic amenities require a comprehensive approach that involves patients and all health workers.

During fieldwork for the larger doctoral study, we heard a common narrative that international migrants both overwhelm and exploit the South African public health care system, exacerbating resource constraints and difficulties in providing quality health care. This narrative was repeated by the public comments from health workers at some of the health facilities, who also expressed xenophobic stereotypes about migrants. Other scholars have also highlighted this narrative of the exploitative and fraudulent migrant (208, 209).

However, during the 69 days that we spent at the 13 facilities, we did not observe the "busloads of migrants" that arrived for health care. Instead, we found variations in the number of international migrants who utilised the 13 facilities. At some facilities, migrant patients constituted a large proportion of people utilising health services, while at others there were very few migrants. The variation in numbers could be explained by the geographic location of health facilities and the surrounding neighbourhoods where migrants from the same country of origin choose to settle. Although we could have missed the phenomenon of the "busloads of migrants" by chance, the narrative of the health care system overwhelmed or exploited by migrants could be explained by the ongoing xenophobic political rhetoric (37). Importantly, several scholars have highlighted the complex factors that explain xenophobia in South Africa. These include the myths and stereotypes about foreigners, caused by the disjuncture between South Africa's progressive laws and implementation, the apartheid legacy of racism directed against African migrants, feelings of superiority, a fear of losing social status and identity, and the perceived threat of foreigners competing with locals for scarce resources and public services (210-213). Nonetheless, it is the responsibility of health policy-makers to ensure that all actors, including those in the health system, uphold the human rights of migrants in line with the Constitution (31).

In this study, busy, frantic or nervous spaces, and contestations between patients and health workers, and among health workers formed part of the social and cultural environment of health care provision. At HF1, we observed the tension between nurses and the clinic clerk who threatened to report the nurses to their managers, because of the large number of

patients waiting to be seen. We could not find other South African studies that have explored the relationship between nurses and clerical staff. A 2005 study at a US hospital found that a tension exists between "the ideal democratic team structure and the reality of a health care hierarchy created by educational differences and traditionally superior–subordinate positions" (214 ,p.103).

We return to our introductory paragraph and the observed interaction between the health care provider and migrant patient, highlighting the negative power of the street level bureaucrat, in this case the health care provider (215). Lipsky (1980) has argued that frontline staff exercise their discretion about "which patients they will help". More recently, scholars have emphasized the complex moral judgements made by health care providers, influenced by their assumptions about those individuals who deserve access to care (170, 216). In this study, the notion of deservingness was illustrated by the health care providers' judgements on whether the sick children of the migrant women at HF1 and HF4 were worthy to receive care. Furthermore, using the social exclusion lens, the interaction also illustrates language as an identifier and as a mechanism for social exclusion (8) during the health care encounter. Hence, the intersection of street level bureaucracy (215), deservingness (216) and social exclusion (8) produced poor HSR for these two migrant women, and their children.

The disturbing incident of the migrant woman with the miscarriage at one of the health facilities reflects the intersection of language barriers, and social exclusionary behaviours of health care providers. The screaming and body language of the woman should have alerted the providers to a potential emergency. We do not know whether their reaction would have been different if they could understand the woman, or if she were not an obvious migrant. Studies in South Africa (63) and Thailand (217, 218) have highlighted the importance of addressing language barriers as part of moving towards migrant-sensitive health systems. However, addressing language barriers cannot be seen in isolation of a broader effort to ensure that migrants' needs are addressed in legislation, policies and the training of health workers, thereby achieving the goal of migrant-sensitive health system (23).

In this study, migrants exercised their agency in different ways. At several of the health facilities, migrant patients rebutted or confronted health workers, despite the potential risks of being refused care or facing verbal abuse. In some instances, they left after long waiting

times, with the expressed intention to return at a later stage. However, leaving the facility is not an option for sick patients, who might need immediate medical attention. A complementary survey among migrant patients at these 13 facilities found complex and nuanced health service experiences, with their perceptions of HSR closely linked to their satisfaction with health workers (142).

Our observations of disrespectful encounters between health workers and migrant patients and their expressed stereotypes or xenophobic views resonate with the findings of other South African studies that highlighted migrants' experiences of medical xenophobia and discrimination (59, 61, 142). In a complementary survey among health care providers at the 13 health facilities, 19.2% of health care providers reported that they had witnessed discrimination against migrants, while 20.0% reported differential treatment of migrant patients (141).

Paradoxically, we observed heart-warming examples of health worker kindness, caring and professionalism in the studied health facilities. This was also found in the survey among migrant patients (142), highlighting the multiple narratives of health care provision for migrants in South Africa. These examples provide hope and a counter-narrative to the challenge of exclusionary health care practices in South Africa. Similarly, Vanyoro (2019), found that health workers in another South African Province endeavoured to provide migrant-friendly health care through language adaptations (135). Hence, an inclusive and human rights approach to health care provision for migrants is likely to result in benefits for all health service users, despite the resource constraints in South Africa's public health sector (14, 47).

Our ethnographic observations were limited to public spaces and outpatients and emergency departments of the selected health care facilities. We did not observe the environment and interactions within consultation rooms or the wards, where different interactions might have been observed. Another limitation is that the study was conducted in the Gauteng Province of South Africa. Hence, the findings cannot be generalized to the health care facilities in other South African provinces. However, Gauteng is host to 47.5% of international migrants in South Africa (55). Hence, this study provides important insights into the environment in which care

is delivered and the daily practices and behaviours of health workers and patients, including migrants.

Conducting ethnographic research among vulnerable groups such as migrants and in a health care setting raises ethical dilemmas. One of the dilemmas is whether the researcher or fieldworkers could or should have intervened with two of the incidents that caused discomfort. Firstly, in the case of the migrant patient shouting in iSiNdebele that she was having a miscarriage and the lack of responsiveness from health care providers, would it have changed anything if the fieldworker (who spoke iSiNdebele) had intervened by relating the urgency to the health care providers of the situation or would it have been a trigger for rude or discriminatory remarks towards the fieldworker (a migrant) and/or the migrant patient? Secondly, in the case of the frail patient in the emergency room who was rushed into the resuscitation area, would the frail patient have had a better outcome if the researcher (a social scientist) had called a health care provider to attend to him sooner? Or would it have caused more harm given that the researcher is not a health care provider who could judge the condition of a patient? The answer is that we do not know. Another dilemma is the risk of perceived interference in healthcare operations, with consequences for other researchers.

Nonetheless, ethnographic observation adds value when done as part of an overall mixed methods approach to explore the experiences of migrants in the health system of host countries (197). The prolonged engagement allowed us to familiarise ourselves with the physical, social and cultural environment of health care provision, and its intersections with patients and health workers (197, 219). At the same time, prolonged engagement is time-consuming, necessitating a well-planned schedule for fieldwork, and careful considerations of logistics and resource requirements.

A major strength of our study is combining the conceptual frameworks on HSR and social exclusion to explore the environment of health care provision for migrant patients in the public health facilities of Gauteng. Our study adds to the discourse and evidence on the experiences of migrant patients in their host countries, and has implications for the notion of a migrant-sensitive health system, and UHC in South Africa.

Conclusion

Using the concepts of HSR and social exclusion, our study demonstrates the influence of the physical, social and cultural environment on health care provision for patients, particularly migrant patients, at 13 public health care facilities in the Gauteng Province of South Africa. Our study draws attention to the multiple narratives in the provision of health care to all patients, including migrants. The professional conduct of health workers who uphold their duties is encouraging, while the disrespectful encounters between health workers and migrant patients require attention, and should be sanctioned. The social and cultural environment, through busy, frantic or nervous spaces, and the contestations between patients and health workers, and among health workers further complicate the provision of health care. The study findings have implications for the achievement of a migrant-friendly health system that is both inclusive of migrants and responsive to their health needs is critical to achieving UHC.

Declarations

Ethics approval and consent to participate

The Human Ethics Research Committee (HREC) Medical of the University of the Witwatersrand in Johannesburg, South Africa provided ethical approval for the study (#: M170988). Permission to access facilities and conduct the fieldwork was obtained from the Gauteng Department of Health (NHRD reference #: GP_201804_019), and the City of Johannesburg municipality.

Consent for publication

Not applicable.

Availability of data and materials

This data is part of a doctoral study, which will be examined in 2021. The ethics number is M170988. The data is available to any Bona fide researchers with appropriate ethics clearance from their institution or on application to the University of Witwatersrand Human Research Ethics Committee (Medical).

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

JAW made substantial contributions to the conception of the work; the acquisition, analysis, and interpretation of data; drafted the paper and revised it. JAW approved the submitted version and agreed to be personally accountable for her own contributions and to ensure that questions related to the accuracy or integrity of any part of the work.

LCR made substantial contributions to the conception, analysis, interpretation of data; and substantively revised it. LCR approved the submitted version and agreed to be personally accountable for her own contributions and to ensure that questions related to the accuracy or integrity of any part of the work.

Both authors read and approved the final manuscript.

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References

The references for this article are included at the end of this thesis.

CHAPTER 6: MIGRANTS PERCEPTIONS OF HEALTH SYSTEMS RESPONSIVENESS AND SATISFACTION WITH HEALTH WORKERS IN A SOUTH AFRICAN PROVINCE

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Migrants' perceptions of health system responsiveness and satisfaction with health workers in a South African Province

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ABSTRACT

Background: There is global emphasis on quality universal health coverage (UHC) that is responsive to the needs of vulnerable communities, such as migrants.

Objective: Examine the perceptions of migrants on health system responsiveness (HSR) and their satisfaction with health workers in public health facilities of a South African Province.

Method: We conducted a cross-sectional study in 13 public health facilities. Following informed consent, we used a semi-structured questionnaire to collect sociodemographic information, patient perceptions of HSR and their satisfaction with health workers. Two open-ended questions gave patients the opportunity to comment on the health facility visit. We applied descriptive and multivariate analyses to our data, and thematic analysis to the qualitative responses.

Results: A total of 251 migrant patients participated in the study, giving a response rate of 80.7%. The majority of patients were female (81.1%), and the mean age was 31.4 years. 30.0% of patients reported that they waited too long; 94.3% that the consulting nurse or doctor listened to them; and 89.4% that they received information about their condition. However, 81.7% said they did not know the name of the consulting nurse or doctor. The mean scores on patients' satisfaction with health workers ranged from 7.0 (95% CI 6.42–7.63) for clerks, 7.7 (95% CI 7.4–8.0) for security guards, 7.4 (95% CI 7.1–7.6) for nurses and 8.3 (95% CI 7.93–8.63) for doctors. The predictors of patient satisfaction with nurses were being given information about their condition; polite treatment, time spent in facility, whether they received prescribed medicines; and stating that they would refer the health facility to family/friends. Four overlapping themes emerged: health workers' attitudes; time waited at the health facility, communication difficulties; and sub-optimal procedures in the health facility.

Conclusion: UHC policies should incorporate migrant patients' perceptions of HSR and the determinants of their satisfaction with health workers.

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Background

Amidst the global discourse on quality universal health coverage (UHC), the world faces an unprecedented migrant crisis [1]. In 2019, an estimated 70 million people were displaced, the majority in low and middle-income countries [1]. Migrants refer to individuals who have moved across an international border, regardless of legal status, the reasons for the movement and/or whether the movement is voluntary or involuntary [2]. Hence, refugees are included in this definition [2]. However, migrants are often excluded from or adversely included in UHC reforms, as was found in a review on the inclusion of migrants in the UHC systems of Indonesia, Malaysia, Philippines, Singapore, and Thailand [3].

Concomitant with the global emphasis on UHC is the recognition that high-quality health systems are linked inextricably to the achievement of such UHC [4]. The 2018 Lancet Global Commission on high-quality health systems highlighted the vulnerability of migrants to poor-quality health care, and recommended research on health system responsiveness (HSR) and research that incorporates patient voices and experiences [5]. HSR is defined as the 'responsiveness of health systems to the legitimate expectations of populations regarding how they are treated' [6]: p.77. HSR has assumed increasing importance since the seminal 2000 World Health Report [7], which underscored the importance of the performance of health systems. HSR focuses on the non-clinical aspects of the quality of the health system (e.g. waiting times and health provider attitudes) [8], and is important for patient satisfaction with the health care system [9]. Patient satisfaction is an important indicator of the quality of care provided, particularly for vulnerable groups such as migrants, who may be at risk of health inequity and social exclusion [10]. In addition, evidence suggests that

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there is a positive correlation between patient satisfaction and health-seeking behaviour [6].

Health care utilisation studies among migrant patients are useful to get an indication of their perceptions of the non-clinical aspects of the quality of the health system (i.e. HSR), their satisfaction with, and their experiences of the health system [11]. In high-income countries, several studies have described the experiences and perceptions of migrants of the health care systems in their host countries [12–20]. A 2010 review of migrants using health care services in high-income countries demonstrated negative associations between patient satisfaction scores and gender, age and education levels [10]. Low patient satisfaction scores were also associated with poor communication, lack of information, and disrespectful interactions with health care providers [10].

Although Canada is known for its inclusive immigration and refugee policies, a 2016 review found that there were cultural, communication, and healthcare system barriers to immigrants' access to primary healthcare (PHC) services [12]. Other studies in the EU found that undocumented migrants underutilised healthcare services, and/or received sub-optimal quality health care, and this was linked to their awareness of their entitlements [14]. In the UK (UK), studies have found that gypsies, travellers and minority ethnic groups experienced high levels of inequalities in the access and/or the quality of care they received in the public healthcare system [15,16]. In Germany [17,18] and Denmark [19], studies found that migrant patients' satisfaction with health care services were influenced by communication by, and cultural sensitivity of, health care providers. A 2016 qualitative study that explored HIV-positive migrants' experiences in the Swedish health care system found that they appreciated access to free antiretroviral therapy, but felt discrimination in health care settings outside of the infectious diseases clinics [21].

Similarly, studies in Africa have highlighted complex and at times contradictory experiences of migrants in the public health sector [22–25]. In Kenya, a study found that both Kenyans, migrants and refugees had similar health service utilisation experiences, but migrants and refugees experienced discrimination as well as language and cost barriers [22]. In Botswana, a 2010 study found that Zimbabwean migrants experienced cost and language barriers, lack of choice of medical practitioner, negative attitudes of medical staff, and fear of police or immigration officials [23]. In Ethiopia, a study among Eritrean refugees in refugee camps found that they had concerns about the limited health care facilities and their inability to access essential health care services [24].

In South Africa, the Constitution states that all people, regardless of citizenship, have the right of access to health care services, and that no one may be refused emergency medical treatment [26]. However, migrants' access to the South African healthcare system is a complex matter. There are contradictions and/or confusion between laws and policies, different interpretations of laws or policy at health facility level [27] and a policy vacuum on migration, health, and migrants' needs [28]. Furthermore, South Africa's public healthcare system struggles to provide high-quality care to people, regardless of their nationality or refugee status [29]. Nonetheless, studies have documented the health care access and/or utilisation barriers faced by migrants or refugees [25,30], exacerbated by lack of legal documents [31], xenophobia and insensitive health workers [32–34]. However, many of these studies are small case studies [25,30–32], with a dearth of quantitative studies on migrant patient satisfaction and their perceptions of HSR.

Importantly, South Africa has committed itself to major health sector reforms, the most prominent of which is the implementation of the National Health Insurance (NHI) system. The latter is a health financing reform intended to pool funds to provide access to quality health services and to reform the health system towards the achievement of UHC [35]. HSR is a critical goal of national health systems [11] and thus, remains important in the realisation of the NHI in South Africa.

In light of the global imperative of quality UHC, we conducted the study to contribute to, and shape, the discourse on quality, and inclusive UHC in South Africa. The overall aim of this study was to examine the perceptions of migrants on health system responsiveness (HSR) and their satisfaction with health workers in public health facilities of a South African Province.

Methods

Study setting and facility sampling

The setting for this cross-sectional study was the public health care system of the Gauteng Province in South Africa. In 2018, Gauteng had an estimated 419 169 international migrants and is reportedly the province with the largest proportion of migrants in South Africa [36].

The public health care system in Gauteng consists of four central, academic referral hospitals, three regional tertiary hospitals, nine regional hospitals, 11 district hospitals, 30 community health centres, and 290 primary health care clinics, and six specialised psychiatric and tuberculosis hospitals [37].

We used a two-stage cluster sampling approach. We selected two facilities randomly from each of the following categories: central hospital; regional

hospital; regional tertiary hospital; district hospital; community health centre; and primary health care clinic. There is only one mother and child hospital in the province; hence, we sampled 13 public health care facilities in Gauteng. Specialised psychiatric and tuberculosis hospitals were excluded because these do not provide ambulatory care services.

Study population

The primary population of interest was migrants using ambulatory care services in public health facilities in Gauteng Province. The eligibility criteria were: an international adult migrant, over the age of 18; seeking ambulatory care; and providing voluntary, informed, written consent to participate in the study. All medical and surgical emergencies were excluded.

Measures

We designed a semi-structured questionnaire in English. The questionnaire consisted of a socio-demographic section (7 questions); experience of the health care consultation and perceptions of HSR (8 items); patients' assessment of their interaction with health workers (5 items).

The section on socio-demographics elicited information on age, gender, education, country of origin, and length of time in South Africa. The section on patients' experiences of the health care consultation incorporated proxy questions on HSR, specifically the domains of prompt attention, communication, confidentiality, dignity, and quality. The total time spent in the health facility was a proxy for the domain of prompt attention, and was measured on a 3-point scale of too long (3), just right (2) or too short (1). The domains of communication, confidentiality, dignity, and quality were measured on a dichotomous scale of yes or no. The domain of communication was measured by three questions: whether the patients knew the name of the health care provider, whether the provider listened to them; and whether they received information on their condition. The domain of confidentiality and dignity were measured on whether their privacy was respected and whether they were treated politely respectively. The domain on quality was measured on whether patients received their prescribed medicine and whether they would refer a sick friend or family member to that particular health facility.

The section on patients' interactions with health workers requested patients to rate the service received from different health worker categories on a scale from 1 (very unhappy) to 10 (very happy). These categories were clerks, doctors, nurses, and security guards. When patients did not encounter the service of a health care worker, they were asked to indicate 'not applicable'.

Two open-ended questions elicited the patients' opinions on their health care visit, HSR and/or quality and their suggestions for health care or quality improvement.

Piloting

Prior to data collection, five health system researchers assessed the content validity of the questionnaire. We piloted the questionnaire at two non-sampled health facilities to determine the clarity of questions, the need for possible adjustments, and the time to complete the questionnaire. We made minor adjustments to the questionnaire to improve clarity of the items asked, and excluded the pilot from the main study results. Cronbach's alpha (CA) for the pilot data was 0.63. This score indicates reasonably good reliability as evidenced by the inter-item correlation.

Data collection

During 2018, fieldwork was conducted on three randomly selected days at each facility. In the case of PHC clinics, we selected three days randomly between Monday and Friday. In the case of community health centres and hospitals, we selected two days randomly between Monday and Friday, and one day randomly on the weekend.

The principal investigator (JW) recruited and trained five fieldworkers to assist with the study. On the fieldwork days, all eligible patients were approached after their health care consultation and upon exiting the relevant facility. Potential participants were informed that participation was voluntary, and that they could withdraw from taking part at any point, without prejudice or negative consequences. They were also reassured of the confidentiality of the study, and that no member of the research team was part of the health care authorities.

Following informed consent, a member of the research team administered the questionnaire using a tablet, with direct data entry into Research Electronic Data Capture (REDCap), a secure, web-based application designed to support data capture for research studies [38]. The principal researcher checked each questionnaire for completeness.

Statistical analysis

We computed descriptive statistics on socio-demographic characteristics and migrant patients' perceptions of HSR and their satisfaction with health workers. For descriptive purposes we categorized both age and number of years living in South Africa. The independent variables included socio-demographic

characteristics i.e. age, gender, highest qualification attained, number of years living in South Africa, and the type of facility utilised e.g. clinic or hospital. We examined the HSR domains (communication, confidentiality, dignity, prompt attention and quality) as both response and explanatory variables.

In the inferential statistics, all variables found to be statistically significant at a 20% level in the unadjusted models were included in the final multiple logistic regression (e.g. did the doctor/nurse listen to you) or ordinal logistic regression (e.g. amount of time spent on the visit). We examined the factors associated with patients' perceptions of HSR, and the relationship between HSR and patient satisfaction with health workers in the multiple logistic and ordinal logistic regression models. For the multiple logistic and ordinal logistic regression analysis, we grouped the 13 health care facilities into three categories: central and regional tertiary hospitals were combined into one category; district and regional hospitals into another; and PHC clinics and community health centres into one category of PHC facilities. We used STATA® 15 for analysis.

Analysis of qualitative comments

We analysed the qualitative comments data using thematic analysis [39]. The analysis was an iterative process beginning with reading and re-reading the comments, before coding the comments. JW and LR read and coded all the comments independently and inductively, i.e. using the participants' own words. These inductive codes were then grouped into broader themes. JW and LR reached consensus on the themes, thereby establishing inter-coder agreement. Once the themes were agreed, JW re-examined the data, and categorised the responses into these themes.

Ethical considerations

The Human Research Ethics Committee (Medical) of the University of the Witwatersrand provided ethical approval for the study (#: M170988). We also obtained permission from the Gauteng Provincial Department of Health (DoH), the district health authorities, and the managers in charge of each of the selected health facilities. We adhered to all ethical procedures during data collection. We provided both written and verbal explanation of the study to all study participants. We only proceeded with the study following study participants' informed, written consent. We adapted an existing distress protocol in the event of negative reactions by the study participants during the interview, with clear referral procedures for assistance [40]. The purpose of the distress protocol was to manage any distress from patients that may arise during data collection, in case any question served as a trigger of a previous negative or traumatic experience in a health facility.

Results

Socio-demographic and patient characteristics

We invited 311 migrant patients across the 13 health care facilities to participate in the study: 251 consented to study participation, translating into a response rate of 80.7%. The majority of participants were female (81.1%), living together/married (69.9%), and from Zimbabwe (55.7%) (Table 1). The mean age of participants was 31.4 years. The majority of participants were recruited at PHC facilities (57.1%) (Table 1). The mean number of years living in South Africa was 6.5 years.

Table 1. Socio-demographic and patient characteristics of the study sample.

Variable	n (%)
Age category	
<25 years	59 (24.5)
25–34 years	104 (43.1)
35+	78 (32.4)
Gender	
Female	202 (81.1)
Male	47 (18.9)
Marital status	
Single/Divorced/Separated/Widowed	75 (30.1)
Living together/Married	174 (69.9)
Place of birth	
East Africa	16 (6.5)
Burundi	3 (1.2)
Ethiopia	3 (1.2)
Kenya	2 (0.8)
Somalia	6 (2.4)
Tanzania	1 (0.4)
Uganda	1 (0.4)
Central Africa	21 (8.7)
Cameroon	1 (0.4)
Democratic Republic of the Congo	20 (8.3)
North Africa	1 (0.4)
Sudan	1 (0.4)
Southern Africa	194 (78.9)
Lesotho	7 (2.8)
Malawi	28 (11.4)
Mozambique	17 (6.9)
Zambia	5 (2.0)
Zimbabwe	137 (55.7)
West Africa	13 (5.3)
Ghana	3 (1.2)
Ivory Coast	1 (0.4)
Nigeria	9 (3.7)
Outside African region: Pakistan	1 (0.4)
Highest qualification	
None/Primary	35 (14.1)
Secondary School	167 (67.1)
Post-secondary/Diploma/Higher	47 (18.9)
Number of years living in South Africa	
< 2 years	32 (13.0)
2–9 years	148 (60.2)
>10 years	66 (26.8)
Patient distribution across health care facility	
Central/Regional Tertiary hospital	63 (25.5)
District/Regional hospital	43 (17.4)
PHC facility	141 (57.1)

Patients' perceptions of responsiveness

In the domain of prompt attention, 55.6% reported that the amount of time for their visit was 'just right', but almost one-third (30.0%) reported that they waited too long (Figure 1).

In the domain of communication, the majority of patients (94.3%) reported that the consulting nurse or doctor listened to them; and 89.4% reported that they received information about their condition. However, 81.7% of patients reported that they did not know the name of the consulting nurse or doctor. For the domain of confidentiality, 93.5% of participants reported that their privacy was respected, while 92.3% of patients indicated that they were treated politely (dignity domain).

Within the domain of quality, the majority of participants reported that they received their prescribed medication (80.6%); and 85.0% of patients indicated that they would refer a sick friend or family member to the facility.

Patients' satisfaction with health workers

The mean scores on patients' satisfaction with the interaction with health workers ranged from a mean score of 7.0 (95% CI 6.42–7.63) for clerks, 7.7 (95% CI 7.4–8.0) for security guards, 7.4 (95% CI 7.1–7.6) for nurses and 8.3 (95% CI 7.93–8.63) for doctors.

Factors influencing patients' perceptions of responsiveness

Table 2(a–d) shows the HSR domain results from the multiple logistic and ordinal logistic regression models.

Domain: communication

In this domain, a multiple logistic regression model was used to investigate factors associated with whether or not the nurse or doctor listened. The binary response variable was whether (1) or not (0) the nurse or doctor listened. The potential explanatory variables were age, place of birth, highest qualification, number of years living in South Africa, and type of facility visited. Education and type of health facility influenced whether patients knew the name of the attending clinician (nurse or doctor). The odds of knowing the name of the attending clinician were significantly higher for those with post-secondary education (OR = 6.23; 95% CI 1.16–33.48; p = 0.036). Similarly, patients from Southern Africa were 6.76 more likely to have received information about their condition (95% CI 1.11–2.67; p = 0.040). In contrast, patients at PHC facilities were less likely to know the name of the attending nurse or doctor (OR = 0.20; 95% CI 0.05–0.71; p = 0.018) (Table 2(a)).

Domain: dignity

In the domain of dignity, a multiple logistic regression model was used to explore the factors associated with patients reporting whether they had been treated politely or not. The binary response variable was whether (1) or not (0) patients reported being treated politely. The potential explanatory variables were age, place of birth, number of years living in South Africa and type of facility visited. Patients from Southern Africa had a higher odds of reporting that they have been treated politely (Table 2(b)), compared to patients from North Africa/West Africa/Other (OR = 5.06; 95% CI 1.26–20.32; p = 0.027).

Domain: prompt attention

We did not find any variables that were associated with patients' perceptions of the waiting times at the health facility (Table 2(c)).

Domain: quality

In this domain, a multiple logistic regression model was used to explore the factors associated with firstly,

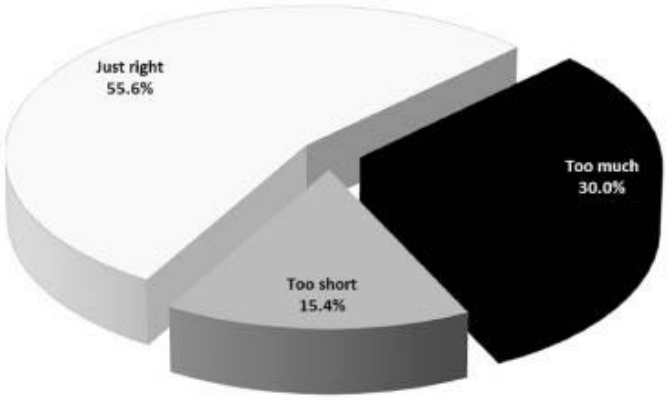


Figure 1. Patient perceptions of time spent in the facility.

Table 2a. Multivariate logistic regression model of socio-demographic and facility factors influencing patients' perceptions of responsiveness (by domain: communication).

		Domain: Communication					
		Do you think the nurse/doctor listened to you?		Do you know the name of the nurse/doctor who attended to you?		Were you given information about your condition?	
Variable		OR	p-value/ CI	OR	p-value/ CI	OR	p-value/ CI
Age						1.07	p = 0.159 0.97–1.19
Place of birth	Reference: North Africa/West Africa/ Outside African region	1	p = 0.250			1	
	East/ Central Africa	1.96	0.50–7.69			2.24	p = 0.382 0.31–16.05
	Southern Africa	4.06	0.70–23.66			6.76	p = 0.040* 1.11–2.67
Highest qualification	Reference: None/Primary			1			
	Secondary			4.12	p = 0.057 0.95–17.87		
	Post-secondary/Diploma/Higher Education			6.23	p = 0.036* 1.16–33.48		
Number of years living in South Africa		1.16	p = 0.168 0.93–1.45	1.04	p = 0.188 0.98–1.11		
Type of facility visited	Reference: Central/Regional Tertiary hospital	1	p = 0.563			1	p = 0.392
	District/Regional hospital	0.73	0.07–7.39	0.32	p = 0.270 0.04–2.77	0.24	0.03–3.01
	PHC facility	0.44	0.09–2.20	0.20	p = 0.018* 0.05–0.71	0.53	0.09–5.18

OR = Odds ratio; CI = confidence interval. Only variables significant at a 20% level were included in the multivariate logistic regression model; *Significance = $p < 0.05$

Table 2b. Multivariate logistic regression model of socio-demographic and facility factors influencing patients' perceptions of responsiveness (by domains: confidentiality and dignity).

		Domain: Confidentiality		Domain: Dignity	
		Do you think your privacy was respected?		Were you treated politely?	
Variable		OR	p-value/CI	OR	p-value/CI
Age		1.06	p = 0.144 0.97–1.16	1.08	p = 0.100 0.98–1.20
Place of birth	Reference: North Africa/West Africa/Other			1	
	East/Central Africa			2.09	p = 0.426 0.29–15.25
	Southern Africa			5.06	p = 0.027* 1.26–20.32
Number of years living in South Africa					
Type of facility visited	Reference: Central/Regional Tertiary hospital			1	p = 0.08
	District/Regional hospital			1.16	0.16–8.22
	PHC facility			0.30	0.08–1.12

OR = Odds ratio; CI = confidence interval. Only variables significant at a 20% level were included in the multivariate logistic regression model; *Significance = $p < 0.05$

Table 2c. Multivariate ordinal logistic regression model of socio-demographic and facility factors influencing patients' perceptions of responsiveness (by domain: communication).

		Domain: Prompt attention	
		Would you say the amount of time you spent for your visit was: too much; just right; too short?	
Variable		OR	p-value/CI
Place of birth	Reference: North Africa/West Africa	1	p = 0.194
	East/Central Africa	0.45	0.09–2.33
	Southern Africa	0.60	0.09–3.71
Type of facility visited	Reference: Central/Regional Tertiary hospital	1	p = 0.925
	District/Regional hospital	0.72	0.08–6.26
	PHC facility	0.80	0.22–2.91

OR = Odds ratio; CI = confidence interval. Only variables significant at a 20% level were included in the multivariate ordinal logistic regression model; *Significance = $p < 0.05$

Table 2d. Multivariate logistic regression model of socio-demographic and facility factors influencing patients' perceptions of responsiveness (by domain: quality).

		Domain: Quality			
		Were you given any of the medicines prescribed for you?		If your friend or relative was sick would you encourage then to come to this clinic or hospital?	
Variable		OR	p-value/CI	OR	p-value/CI
Gender	Reference: Male			1	p = 0.034*
	Female			0.34	0.13–0.90
Age		1.02	p = 0.319	1.03	p = 0.053
			0.97–1.08		0.10–1.07
Place of birth	Reference: North Africa/West Africa			1	p = 0.098
	East/Central Africa			0.38	0.04–3.95
	Southern Africa			1.67	0.16–17.94
Highest qualification	Reference: None/Primary	1	p = 0.053		
	Secondary	3.01	0.98–9.21		
	Post-secondary/Diploma/Higher	5.74	p = 0.031*		
			1.21–27.18		
Number of years living in South Africa		1.02	p = 0.297		
			0.97–1.08		
Type of facility visited	Reference: Central/Regional Tertiary hospital	1	p = 0.904	1	p = 0.414
	District/Regional hospital	1.32	0.33–5.29	2.44	0.45–13.29
	PHC facility	1.03	0.40–2.66	0.75	0.26–2.15

OR = Odds ratio; CI = confidence interval. Only variables significant at a 20% level were included in the multivariate logistic regression model; *Significance = $p < 0.05$

whether patients had been given their prescribed medicines and secondly, whether patients would encourage a sick friend or relative to come to the clinic or hospital. The binary response for both variables were (1) yes or (0) no. The potential explanatory variables for whether patients had been given their prescribed medicines were gender, age, place of birth, highest qualification, number of years living in South Africa and the type of facility visited. Compared with those with no or primary education, patients with post-secondary, diploma or higher education were 5.74 times more likely (95% CI 1.21–27.18; p = 0.031) to indicate that they received medication (Table 2(d)).

The potential explanatory variables for whether patients would encourage a sick friend or relative to come to the clinic or hospital were gender, age, place of birth, number of years living in South Africa, and type of facility visited. Female patients were less likely to refer a sick friend or relative to the health facility (OR = 0.34 95% CI 0.13–0.90; p = 0.034).

Relationship between HSR and patient satisfaction with health workers

Patients who were treated politely were 4.79 times more likely to be satisfied with clerks (95% CI 1.81–2.11). Similarly, patients who would refer the facility to a family member or friend were 1.50 times more likely to express greater satisfaction with clerks compared to those who would not refer (95% CI 1.00–2.24).

Patients who reported that time spent at the facility were shorter than expected, were 4.79 times more likely to express satisfaction with doctors (95% CI 0.44–16.00). Similarly, patients who reported that time spent at the facility were just right, were 4.15 times more likely to express satisfaction with doctors (95% CI 0.72–10.01), compared to patients who indicated that time spent at the facility were too long.

The odds of patient satisfaction with nurses were higher for those patients who reported that they received information about their condition compared to those who did not (OR = 2.68; 95% CI 1.45–4.97). Likewise, the odds of increased satisfaction with nurses were four times higher for patients who were treated politely (OR = 4.91; 95% CI 1.68–14.33).

Patients who indicated time spent at the facility was just right (OR = 2.53; 95% CI 1.53–4.18) or shorter than expected (OR = 2.70; 95% CI 1.22–-5.96) had higher odds of reporting increased satisfaction with nurses, compared to those who reported that time spent at the facility was too much. Similarly, the odds of satisfaction with nurses were higher for patients who received their prescribed medicines (OR = 1.74; 95% CI 1.01–-2.98). Likewise, patients who would refer the facility to a sick family member or friend had higher odds of expressing satisfaction with nurses compared to those who would not (OR = 2.38; 95% CI1.43–3.96). Table 3 shows the association between the HSR variables and patient satisfaction with health workers.

Qualitative themes

Although overlapping, four themes emerged from the qualitative comments: health workers' attitudes; time waited at the health facility, communication difficulties during consultation; and sub-optimal procedures in the health facility.

Table 3. Multiple ordinal logistic regression model of HSR and patient satisfaction with health workers.

		Category of health care worker							
		Clerks		Security guard		Doctor		Nurse	
Variable		OR	Confidence Interval	OR	Confidence Interval	OR	Confidence Interval	OR	Confidence Interval
Communication	Do you think the nurse/doctor listened to you? (Reference: no)					3.39	0.27–42.53		
	Were you given information about your condition? (Reference: no)					0.34	0.09–1.27	2.68	1.45–4.97*
Confidentiality	Do you think your privacy was respected? (Reference: no)					0.86	0.15–4.88	1.32	0.19–9.01
Dignity	Were you treated politely? (Reference: no)	4.79	1.81–2.11*			16.15	0.25–1032.20	4.91	1.68–14.33*
Prompt attention	Would you say the amount of time you spent for your visit was:								
	Too Much (reference)					1		1	
	Just Right					4.15	0.72–10.01*	2.53	1.53–4.18*
	Too Short					4.79	0.44–16.00*	2.70	1.22–5.96*
Quality	Were you given any of the medicines prescribed for you? (Reference: no)							1.74	1.01–2.98*
	If your friend or relative was sick would you encourage then to come to this clinic or hospital? (Reference: no)	1.50	1.00–2.24*	2.06	0.62–6.77	0.83	0.24–2.89	2.38	1.43–3.96*

OR = Odds ratio; CI = confidence interval. Only variables significant at a 20% level were included in the multivariate ordinal logistic regression model; *Significance = $p < 0.05$

Health workers' attitudes

Patients' comments on the attitudes of health workers were both positive and negative aspects. Their positive comments included friendliness or politeness, and 'good' attitudes or treatment.

> *"I was treated very well, even health providers were friendly"* (Male, Zimbabwe, Specialised hospital)

> *"Good. Staff received me well and all the things went well."* (Female, Ivory Coast, Clinic)

In contrast, some patients described poor, uncaring attitudes, lack of sympathy, and sub-optimal treatment from health workers. Some patients highlighted the labour ward and emergency unit as problematic spaces for health care.

> *"I didn't like their treatment. I was robbed and injured and expected some sympathy and care"* (Male, Zimbabwe, District hospital)

> *"First I would tell them to treat people nicely in emergency. When I bring the baby to casualty, they say why I don't go to the clinic. But [the] clinic is closed. They don't talk nice to me. Many nurses from here are not nice but doctors are nice"* (Female, Tanzania, Specialised hospital)

Some patient comments highlighted the intersection between nationality or being foreign, poor treatment, negative attitudes, and language difficulties.

> *"They are rude especially to foreigners who do not understand the language ... "* (Female, Mozambique, Clinic)

> *"As a foreigner I feel that nurses discriminate because of nationality"* (Female, Zimbabwe, CHC)

Patients' experiences of time spent at the health facility

Some patients voiced their dissatisfaction about the long time spent at the health facility, having arrived the previous day, and returning on the day of the fieldwork, while others linked long waiting times to 'slow' staff.

> *"It was bad, waiting since yesterday until now. We got here at 11.30am."* (Female, Malawi, Regional hospital)

> *"I have been here since last night, got injury on my leg only to be attended now, hungry and pains"* (Male, Somalia, Central hospital)

> *"Bad, many people were even complaining saying that the staff is very slow today which lead to longer waiting times."* (Male, DRC, Central hospital)

One patient explained that although she waited four hours for assistance, she was happy with the service she received.

> *"I arrived at 6 and at about 10 am, I was done which is good. I have no complaints"* (Female, Malawi, CHC)

Communication difficulties during health care consultations

Some patients reported the problems of poor or absent communication and information, exacerbated by language differences.

> *"Things are mixed up. They* [health workers] *don't know who is coming for what. Staff need to provide better information to patients"* (Female, DRC, District hospital)

"*Difficult to understand the language*" (Male, Burundi, Clinic)

Sub-optimal procedures in health facility

In this theme, patients highlighted the deficiencies that existed within the health facility, such as the administrative burden or procedures, constant administrative changes, as well as a general lack of organisation.

"*There is too much administration and it leads to longer waiting hours. [I] had a referral letter from the clinic but was sent to the gateway clinic and back which was unnecessary and strenuous for us and our sick baby*" (Female, Zimbabwe, District hospital)

"*Not well organized. Every month you come, things are different. Things change every month.*" (Female, Nigeria, District hospital)

Discussion

This study aimed to examine the perceptions of migrants on health system responsiveness (HSR) and their satisfaction with health workers in public health facilities. We also assessed the relationships between socio-demographic and health facility characteristics and HSR, and the association between HSR and patient satisfaction with health workers.

In 2018, the demographic profile of migrant patients utilising public health facilities in the Gauteng Province of South Africa were female (82.0%), and the mean age was 31.5 years. In this study, 55.7% of patients surveyed were from Zimbabwe, the northern neighbour of South Africa. This finding is not surprising, given the proximity of Zimbabwe to South Africa, and the virtual collapse of the health system in that country [41].

Although 54.6% of patients reported that the amount of time for their visit was 'just right', almost one-third (30.0%) complained about long time that they spent at the health facility. Complaints about waiting times also emerged in the qualitative comments, with some patients highlighting that they arrived the previous day, but had to return, and wait again. We could not find other comparable studies in South Africa that surveyed migrant patients about their perceptions of waiting times. However, the figure of 30.0% of migrant patients who felt that the waiting times were too long is similar to the findings of the 2010 General Household Survey, showing that 34.8% of South African adults reported that long waiting times were the most common problem experienced during their most recent visit to a healthcare provider [42]. These findings suggest that waiting times are a problem for all individuals utilising public health services. Our study findings are supported by the 2016/17 inspection report of the Office of Health Standards Compliance (OHSC) that found that Gauteng had the longest waiting times when compared to other provinces [43].

A possible explanation for the majority (55.6%) of migrant patients' apparent satisfaction with waiting times could be because of their prior expectations (whether in their home country or South Africa) that waiting times would be longer than the actual time spent at health facilities. Although the context is different, the influence of prior expectations on patient satisfaction with waiting times was also found in a Canadian study [44]. In the regression model, we could not find any variables that were associated with migrant patients' perceptions of waiting times. However, a qualitative study in the USA found that patients' 'willingness to wait' was influenced by the actual wait time, the perceived value of the visit, the cost of waiting, and health facility and provider factors [45]. Hence, this area needs further research in South Africa.

Although the majority of patients (94.3%) indicated that the health care worker listened to them and that they received information about their condition (89.4%), the qualitative comments revealed the problems of insufficient information and inadequate communication about health service delivery. Patients also complained that they did not understand the language spoken. Other South African studies show that some health care providers refuse to speak in English, making it difficult for migrant patients to understand them [46,47]. Language barriers in the health care setting are a common problem found in studies with migrant patients in the UK and Germany [17,48].

In our study, 81.7% of patients reported that they did not know the name of the attending nurse or doctor. However, those migrant patients with secondary and post-secondary education were more likely to know the name of the attending health provider. This could be because those patients with secondary or post-secondary education noticed and remembered the name badges of health care providers, as it is one of the quality of care standards in South Africa [49]. It could also be that patients with higher education levels ensured mutual introduction between themselves and the attending health provider.

We also found that patients at PHC facilities were significantly less likely to know the name of the attending health care provider. This could be because health workers do not wear name tags, an area that the OHSC flagged for improvement in its 2016/2017 inspection report of the Gauteng Province [43].

The vast majority of patients indicated that they were treated politely. Patients from Southern Africa were more likely to indicate that they were treated politely during their visit to the health facility. This is surprising and could relate to prior expectations or

past experiences in South Africa [45], the resource constraints of the health systems in their home countries [41], and/or the similarities of indigenous languages in these countries, with those in South Africa.

The majority of participants (80.6%) reported that they received their prescribed medication. Those with secondary or post-secondary education were more likely to indicate receiving their prescribed medicines. We could not find other studies demonstrating a relationship between education levels and receipt of prescribed medicines. However, there is global evidence of the positive correlation between higher levels of education, health and well-being, and utilization of preventive services [50,51]. It could be that those migrant patients with more years of education were more likely to pay attention to medicines prescribed, request medication from the provider, and/or ensure that they received prescribed medication.

Although the majority of patients said that they would refer a sick friend or family member to the facility, female patients were less likely to refer the facility to a family member or friend. This could be because health service utilisation among women tends to be higher than among men [52–54], and the majority of patients in this study were women. Thus, their experiences of the facility may have influenced their responses on whether they would refer friends or family members.

Clerks received the lowest satisfaction mean score of 7.0. This could be because clerks are often the gatekeepers to clinical care services in health facilities, because they register patients and prepare the medical files. Those patients who reported that they received polite treatment were more likely to indicate satisfaction with clerical services.

Nurses received a lower patient satisfaction mean score of 7.4, compared to doctors who received the highest satisfaction mean score of 8.3. In part, this is because of the numerical dominance of nurses, who are the category of health workers that patients are more likely to encounter. Although some patients commented positively on nurses, there were also complaints about nurses' uncaring attitudes and perceptions of discrimination. Similar complaints on the uncaring attitudes of nurses were also described in the 2010 Consolidated Report on Inspections of Primary Health Care Delivery Sites in Gauteng [55]. Hence, the health minister declared 'values and attitudes' as a priority for action and monitoring. Although the OHSC inspection report for 2016/17 found that Gauteng Province obtained the highest score of 68% for values and attitudes, the OHSC highlighted that this priority area needs ongoing attention [43].

The patient complaints about discrimination because of nationality are of concern, and have been found in other studies as well [21,56]. We did not ask patients explicitly whether they experienced discrimination, and this needs further research. Nonetheless, discrimination is unacceptable, and all health managers should put in place systems to prevent discrimination, and to ensure that health workers uphold their ethical obligations. In this study, patients who indicated that they were treated politely, given information about their condition, received prescribed medicines and would refer the health facility to family and friends were more likely to express higher satisfaction with nurses. This suggests a close relationship between perceptions of HSR and satisfaction with health workers.

Our study found that those patients who indicated that the time spent in the health facility were just right or shorter than expected, were more likely to express satisfaction with the attending nurse or doctor. A 2017 South African study on patient satisfaction with nurse PHC delivery also demonstrated a positive relationship between shorter waiting times, and patient satisfaction with nursing care [57]. Although not comparable because of context and variations in measurement and study design, studies from China, OECD countries and the USA have found inverse relationships between waiting times and patient satisfaction [58–61]. Hence, the reduction of waiting times for all patients remains a priority in the South African public health system.

Our study is limited by its cross-sectional nature, as it represents the views of migrant patients at a point in time. Another limitation is that we conducted the study in one South African Province, which means that the study is not generalisable to the entire country. We conducted our study in English, which is a second language for many migrants, and this might have constrained their ability to comment extensively. Our study surveyed migrant patients utilising services at the health care facilities, rather than examine perceived access barriers. Hence, our findings are a reflection of these patients already in the health care system, and may not be generalizable to all migrants. Lastly, although we reassured participating patients of the independence of the research team, some responses may have been guarded. Although we included a range of socio-demographics, we did not include employment and level of income in our questionnaire – this is a study limitation and we would not be able to explore socio-economic status of those participants in our study.

However, there are numerous study strengths. This was one of the first comprehensive surveys that examined migrants' perceptions of HSR, and their satisfaction with health workers. We obtained a high response rate among migrant patients, thus overcoming the potential bias of non-response. We selected the facilities and fieldwork days randomly, thus overcoming the potential problem of selection bias. The open-ended questions allowed study participants to narrate their experiences of the health facility visit in their own words, thus adding valuable insights into migrant patients' experiences in Gauteng public health facilities.

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The survey questionnaire can be used or adapted by other researchers to measure HSR and patient satisfaction, whether in South Africa, other LIMICs, or among other vulnerable groups of patients.

The gaps identified in our study such as perceived long waiting times, sub-optimal communication, and uncaring attitudes of frontline health workers have occupied the health policy reform agenda since democracy, and remain critical priorities to address [62]. The 2019 South African Lancet National Commission recommended improved leadership and governance, revolutionising quality of care, investment in the health workforce, and measurement, monitoring and evaluation to achieve of a high quality health system [62]. The implementation of these recommendations are likely to benefit all patients, regardless of nationality, in the South African public health system.

Conclusion

This study examined migrants' perceptions of HSR and their satisfaction with health workers. Our study illustrates that migrant patient satisfaction and their experiences are complex and nuanced. We found that perceptions of HSR are closely linked to satisfaction with health workers.

Further research should incorporate the factors that influence migrants' access to care, compare the experiences of migrant patients to those of South Africans, and complement the HSR survey with in-depth qualitative studies over a longitudinal period.

HSR and patient satisfaction are important elements of quality UHC. However, vulnerable groups, such as migrants, are at risk of exclusion from the health care systems of their host countries. In South Africa, as elsewhere, quality UHC is a priority. Our study findings should be incorporated into the design of inclusive UHC policies, so that all patients, regardless of nationality, can benefit from high-quality public health systems.

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Author contributions

JW: Conceptualization, methodology, project administration, analysis, writing and editing, literature references.
JL: supervision of quantitative data analysis, writing and editing.
LR: Conceptualization, methodology, analysis, writing and editing, supervision, literature references, funding contribution.

Disclosure statement

The authors declare that they have no competing interests.

Funding information

The study was funded from Professor Rispel's South African Chair through the National Research Foundation. The funding covered fieldwork costs during data collection, including fieldworker stipends and logistical arrangements (e.g. car hire & fieldworker training).

Data availability statement

This data is part of a doctoral study, which will be examined in 2020. The ethics number is M170988. All patients gave their consent for confidential participation before participating in the survey. No personal information was collected. Data access is limited for ethical reasons to controlled access within the Redcap server. The data is available to any Bona fide researchers with appropriate ethics clearance from their institution or on application to the University of Witwatersrand Human Research Ethics Committee (Medical). However, all data is available outside of the Redcap server to accredited peer reviewers on a specific peer review access.

Ethics and consent

Ethical clearance (M170988) to conduct the study was obtained from the University of the Witwatersrand Human Ethics Research Committee (MEDICAL) and procedures followed during the study were in accordance with the Singapore Declaration on Research Integrity of 2010, available at: www.singaporestatement.org

Funding information

The study was funded from Professor Rispel's South African Chair through the National Research Foundation. The funding covered fieldwork costs during data collection, including fieldworker stipends and logistical arrangements (e.g. car hire & fieldworker training).

Paper context

Within the global context of achieving high-quality universal health coverage (UHC), the world faces an unprecedented migrant crisis. This study generated new knowledge on migrant patients' perceptions of health system responsiveness (HSR) and their satisfaction with health workers in public health facilities of a South African Province, as well as the factors that influence these perceptions. The study findings have implications for the design of inclusive UHC policies.

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CHAPTER 7: SOCIAL EXCLUSION AND THE PERSPECTIVES OF HEALTH CARE PROVIDERS ON MIGRANTS IN GAUTENG PUBLIC HEALTH FACILITIES, SOUTH AFRICA

PLOS ONE

RESEARCH ARTICLE

Social exclusion and the perspectives of health care providers on migrants in Gauteng public health facilities, South Africa

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Data Availability Statement: The Human Research Ethics Committee (HREC) (Medical) of the University of the Witwatersrand in Johannesburg has imposed restrictions on the data, because it

Abstract

Background

Universal health coverage (UHC) for all people, regardless of citizenship, is a global priority. Health care providers are central to the achievement of UHC, and their attitudes and behaviour could either advance or impede UHC for migrants. Using a social exclusion conceptual framework, this study examined the perspectives of health care providers on delivering health services to migrants in public health facilities in Gauteng Province, South Africa.

Methods

We used stratified, random sampling to select 13 public health facilities. All health care providers working in ambulatory care were invited to complete a self-administered questionnaire. In addition to socio-demographic information, the questionnaire asked health care providers if they had witnessed discrimination against migrants at work, and measured their perspectives on social exclusionary views and practices. Multiple regression analysis was used to identify predictors of more exclusionary perspectives for each item.

Results

277 of 308 health care providers participated in the study–a response rate of 90%. The participants were predominantly female (77.6%) and nurses (51.9%), and had worked for an average of 6.8 years in their facilities. 19.2% of health care providers reported that they had witnessed discrimination against migrants, while 20.0% reported differential treatment of migrant patients. Exclusionary perspectives varied across the different items, and for different provider groups. Enrolled nurses and nursing assistants were significantly more exclusionary on a number of items, while the opposite was found for providers born outside South Africa. For some questions, female providers held more exclusionary perspectives and this was also the case for providers from higher levels of care.

contains sensitive and confidential information on health care providers. Researchers who meet the criteria for access to confidential and sensitive data can contact the university's senior information scientist (nina.lewin@wits.ac.za), or the HREC administrator (zanele.ndlovu@wits.ac.za).

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Competing interests: The authors have declared that no competing interests exist.

Conclusion

Health care providers are critical to inclusive UHC. Social exclusionary views or practices must be addressed through enabling health policies; training in culture-sensitivity, ethics and human rights; and advocacy to ensure that health care providers uphold their professional obligations to all patients.

Introduction

This millennium has been marked by mass migration [1]. In 2019, an estimated 70 million people were displaced globally [2]. In this paper, migrants refer to people who have moved across an international border away from their habitual place of residence, regardless of their legal status, causes of the movement, or whether it was voluntary or involuntary [3]. Worldwide, the unmet health needs of migrants and their lack of access to essential health services are of concern [4]. Consequently, a major global priority is to achieve universal health coverage (UHC) for all people, regardless of citizenship [4]. UHC implies the mainstreaming of migrant health into country-level reform agendas, the promotion of migrant-sensitive health policies [4], and the development of responsive health systems [5]. Human resources for health (HRH) are central to the achievement of UHC, because health care providers are the personification of responsive health systems [6]. Hence, their attitudes, behaviour or practices could either advance or constrain the achievement of UHC for vulnerable individuals, such as migrants [7].

In South Africa there is contestation about the number of migrants, but the 2011 census estimated around 2.2 million immigrants, with a total population of 51.8 million people [8]. In 2020, the International Organization of Migration (IOM) estimated this number to be around 4 million; and highlighted that South Africa was one of the top 20 destinations for migrants, due to an increase in intraregional migration [9]. According to the IOM, the majority of migrants in South Africa came from neighbouring Mozambique and Zimbabwe [9].

Legally, there is a constitutional right to health care for all individuals regardless of nationality, but access to health services for migrants is complex, especially for those without formal documentation [7]. This is partly due to the significant challenges faced by government in providing high-quality health care in the public health sector [10]. At the health facility level, the decisions of hospital managers or administrators could exclude migrants from health care, which is contrary to the Constitution and a violation of their human rights [11]. The proposed National Health Insurance (NHI) system is the country's primary UHC reform, aimed at addressing the entrenched inequities in its two-tiered health system [12]. Although the NHI policy document lacks clarity on health care for migrants and refugees [12], Chapter 2 of the 2019 NHI bill makes provision for complete cover for permanent residents, refugees, and asylum seekers, but only limited cover for "illegal foreigners" [13][p.8].

Research on migration has focused on the legal instruments for protecting the human rights of migrants and refugees [14], health inequities and unmet health needs of migrants and refugees [15], health policy or system deficiencies [5], and migrant or refugee experiences and perceptions of health services in the host countries [16]. A systematic review on health care provider experiences of providing care to migrants and refugees found major challenges related to diverse cultural beliefs, limited institutional capacity, and the inconsistency between health professional ethics and country-specific legislation that often limits migrants' right to health care [17]. A 2017 systematic review of health professionals in primary health care (PHC) settings providing care to refugees and asylum seekers found that political decisions

affect frontline clinical practice, resourcing priorities, health professional roles and healthcare access [18]. The health professionals reported that encounters with refugees and asylum seekers were influenced by cultural differences, and a lack of knowledge of the more complex health problems. They were also exacerbated by health system challenges such as a lack of training, insufficient time or professional support to manage complex health problems, referral difficulties, increased costs, and staff shortages [18]. All of these health system challenges were experienced within a fluid and changing policy environment, and widespread hostility of policymakers to migrants [18, 19].

In Africa, a 2018 WHO report underscored the dearth of empirical information on health care to migrants and the ethical responsibilities or professional duties of health care providers [20]. In South Africa, Matlin *et al* [7] have pointed out that despite an enabling legal framework, health care access for migrants is variable in practice and influenced by health system factors, health managers' responsiveness and xenophobic attitudes by health professionals. In a 2011 qualitative study with Zimbabwean migrants in Cape Town and Johannesburg, Crush and Tawodzera [21] coined the term "medical xenophobia", defined as the "negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job" [p.655]. Medical xenophobia included the insistence by managers or health care providers that patients show identity documentation prior to receiving care [21]. It also included delay or denial of treatment on the basis of nationality, refusal to communicate with patients in a common language (such as English) or to allow the use of translators, and/or verbal abuse and xenophobic statements and insults [21]. A 2017 qualitative study in Durban, South Africa described the medical xenophobia faced by refugees from the Democratic Republic of Congo (DRC) including the insistence on documentation, insensitive comments and other discriminatory practices from providers [22]. Another small qualitative study that explored the experiences of eight women refugees and their attempts at utilising reproductive health care services in Durban's public sector also reported incidents of medical xenophobia [23]. A final small ethnographic study with 21 HIV positive Mozambicans found that their access to health care services was constrained due to structural vulnerabilities and HIV stigma [24].

However, all of these South African studies were qualitative in design and none of them focused on health care providers. The aim of this study was to examine the perspectives of health care providers on delivering health services to migrants in public health facilities in the Gauteng Province of South Africa. A quantitative approach allowed us to obtain a representative view on health care providers' perspectives on social exclusionary views or practices; and to investigate the relationships between demographic; the type of facility and health care providers' perspectives or practices. The paper contributes to an emerging literature that examines quality UHC for migrants from the perspective of health care providers.

Material and methods

Conceptual framework

In this paper, we draw on the social exclusion conceptual framework of the Social Exclusion Knowledge Network (SEKN) to examine the experiences and perspectives of health care providers on migrants utilising public health services in the Gauteng Province of South Africa [25]. The concept and measurement of social exclusion remains contested, illustrated by a 2019 scoping review that highlights different definitions and variations in the measurement of social exclusion [26].

The SEKN defines social exclusion as the "dynamic, multidimensional processes driven by unequal power relationships, interacting across economic, political, social and cultural dimensions and at individual, household, group, community, country and global levels" [25][p36]. In

this study, we examined social exclusion within the health system, specifically the perspectives of health care providers (the personification of the health system) and migrants (a potentially excluded group).

A relational approach to social exclusion has a number of advantages [25]. Firstly, it underscores the complexity and dynamics of the notion of social exclusion embedded in relationships. Secondly, it highlights the salience of identity (in this case nationality) that serves to exclude migrant patients. Thirdly, a relational approach enables an exploration of the linkages between social exclusion and human rights (e.g. non-discrimination). Lastly, a relational approach can elucidate the perspectives of health care providers of migrant patients that generate and/or sustain broader exclusionary processes [25].

Study design and setting

This is a cross-sectional analytical study conducted in public health care facilities in the Gauteng Province of South Africa.

The study setting was all the public health care facilities in Gauteng Province. The province is the most densely populated in South Africa, with an estimated total population of 14.7 million [27]. In 2018, Gauteng Province was host to the largest proportion of migrants (47.5%) in South Africa [27].

In Gauteng Province, the public health care system consists of four central hospitals, that provide highly specialised quaternary and/or tertiary services, serve as referral hospitals for lower level facilities, and are attached to university health science faculties that train health professionals [28]. There are also two regional tertiary hospitals that are attached to health science faculties and provide some tertiary and other specialised services, and nine regional hospitals that provide specialised secondary services in internal medicine, general surgery, paediatrics, obstetrics and gynaecology and general surgery. The province has one specialised mother-and child-hospital that functions at the level of a regional hospital, with some tertiary services. The 11 district hospitals in the province provide general, inpatient hospital services, and the six specialised hospitals provide psychiatric services, tuberculosis services, infectious diseases and rehabilitation services [28]. The primary health care (PHC) system consists of a network of 30 community health centres (CHCs) and 290 PHC clinics that provide ambulatory care services. The CHCs are open 24 hours per day, seven days per week, while the PHC clinics are open during office hours from Monday to Friday.

The study population consisted of all health care providers that provide ambulatory care services in Gauteng public health facilities. This included medical doctors (both generalists and specialists), professional nurses (with four years of training), enrolled nurses (with two years of training), and nursing auxiliaries or assistants (with one year of training), dentists, occupational therapists, physiotherapists, and pharmacists [29]. We obtained data on health professionals from the Gauteng Department of Health, which showed that in 2018 there were a total of 5102 medical doctors, 12058 professional nurses, 6424 enrolled nurses, 6050 nursing assistants, and 3288 allied health professionals.

Sampling of facilities

We used stratified, random sampling to select the public health care facilities from the master list of health care facilities in Gauteng Province (obtained from the Gauteng Department of Health). Facilities were stratified by type as follows: central hospital, regional tertiary hospital, regional hospital, district hospital, community health centres, PHC clinics, and a mother and child hospital. We selected two facilities randomly from each stratum, except in the case of the

mother and child hospital, where there is only one. Hence, we sampled 13 public health care facilities in Gauteng.

Measures

We designed a self-administered questionnaire that obtained information on the socio-demographic profile of health care providers, and that measured social exclusionary views or practices. The questions on social exclusion were based on an extensive literature review and drew on the SEKN conceptual framework [25].

The socio-demographic questions elicited information on age, gender, marital status, category of health care provider, and number of years worked in the health care facility. We measured social exclusionary practices and views among health care providers in two ways. Firstly, health care providers were asked if they had witnessed discrimination or differential treatment of migrants at work (two separate questions measured by yes or no response). Secondly, the health care providers were asked to rate their agreement with seven statements on social exclusionary views or practices (seven questions measured on a seven-point Likert scale from strongly disagree (1) to strongly agree (7)). The seven statements intended to measure the social exclusionary views or practices of health care providers, focused on examples of medical xenophobia, health professional obligations in relation to migrants, and coverage of migrants in the NHI system. Three of the questions were phrased positively (where higher agreement indicates less exclusionary attitudes), and four were phrased negatively (lower agreement indicates less exclusionary attitudes).

We piloted the questionnaire with five health care providers of different categories at a hospital, clinic and community health centre that were not part of the selected facilities to determine clarity of questions and the time taken to complete the questionnaire. Based on the feedback we received, no changes to the provider SAQ were required.

Preparation for data collection

Prior to data collection, we obtained permission for the study from the relevant authorities (Gauteng Department of Health (GDoH), and the City of Johannesburg), and from each of the sampled health facilities. The ethical approval from the Human Research Ethics Committee (HREC) (Medical) was also included.

The principal researcher (JW) included a cover letter or email to the documents. This cover letter highlighted the following: that 3 days would be selected randomly for data collection, that health care providers on duty in ambulatory care would be approached, and invited to participate in the study, that participation was voluntary, and that the principal researcher and the research team will not interfere with patient care or the duties of health workers.

Due to the number of health care facilities in the study, the principal researcher recruited fieldworkers to assist with data collection. The principal researcher ensured prior training of each of the other members of the research team, using a detailed field manual that stressed ethical conduct, professionalism, and confidentiality. The research team consisted of three South Africans, one national from Ghana and two nationals from Zimbabwe.

The principal researcher liaised with the health facility manager at each hospital, or clinic prior to data collection. Once the data collection days were selected randomly for each facility, the principal researcher ensured that the manager in charge of the facility was aware of the selected days, and that the research team would arrive before 7 am in the morning. On the survey days, the principal researcher, announced the presence of the research team and introduced the team to the manager on duty.

Data collection

We conducted the study between April and December 2018 at the 13 selected public health care facilities. For primary health care clinics, we selected three separate days randomly between Monday and Friday. In the case of community health centres and hospitals, we selected two days randomly between Monday and Friday, and one day randomly on the weekend.

The research team recruited health care providers on the randomly selected fieldwork days at each of the selected facilities. The eligibility criteria for participation in the study was working in ambulatory care in the facility, which meant outpatient or emergency medical department for the hospitals. A member of the research team approached an eligible health care provider during their tea or lunch break, explained the study verbally, and offered each participant the study information sheet. The information sheet contained background on the study, the confidential and voluntary nature of the study, the participant's rights, including withdrawal at any point, no incentives or penalties, and the contact details of the HREC and the study supervisor. All participants gave voluntary, informed, written consent.

We used mobile device/tablet for data collection, with the self-administered questionnaire preloaded on the tablet. Once the initial approach was made to the eligible health care providers and they agreed to participate in the study, the tablet was handed to the health care provider to complete the survey, with direct data entry into Research Electronic Data Capture (REDCap). The latter is a secure web-based programme hosted at the University of Witwatersrand [30]. Each participant had to provide written consent, by indicating yes or no on the tablet. A no response would take them out of the survey. During completion of the survey, a member of the research team stood a distance away from participants to allow for privacy, but close enough to answer any questions. No health facility supervisor or manager was present during survey completion. The health care providers did not receive anything for participating in the study.

Statistical analysis

We used Stata® 15 to analyze the data. Frequency tabulations were done to describe the socio-demographic and employment characteristics of the study participants.

The analysis took account of the complex sampling design using the svyset command in Stata. We used the GDoH data on all health professionals by category and health facility to calculate the weights for analysis. All analyses were weighted to reflect the distribution of health care providers, by type of health facility and health worker category, at the provincial level. For analysis we combined: central hospitals, regional tertiary hospitals and specialised mother and child facility into one category, called "tertiary hospitals"; and clinics and community health centres into "primary health care (PHC) facilities". In the case of health care provider, we combined all the enrolled nurses and nursing assistants into one category, called enrolled nurses and nursing assistants. We also adjusted standard errors for clustering at the health facility level.

We used frequency tabulations to show the proportion of health care providers reporting that they witnessed discrimination against, or differential treatment of, migrants. We computed the mean and standard deviations for the 7-point Likert scale items that measured social exclusionary views or practices. Bivariate analysis was done to investigate the relationship between the socio-demographic and employment characteristics of health care providers and each of the social exclusionary items. All the factors found to be statistically significant at a conservative level of 20% level were included in the multiple regression models, which were evaluated for each of the items separately. All tests were conducted at a 5% significance level.

Ethical considerations

We obtained ethical approval from the HREC (Medical) of the University of the Witwatersrand in Johannesburg (Certificate #: M170988). We also obtained permission from the Gauteng Department of Health through the National Health Research Database (NHRD reference #: GP_201804_019). All participants received a detailed study information sheet, and provided written consent, via REDCap (Research Electronic Data Capture) [30]. We complied with the Singapore Declaration of research integrity [31] and adhered to all ethical procedures, including informed consent, voluntary participation, confidentiality and anonymity.

Results

We obtained a 89.9% response rate, with 277/308 health care providers participating in the study (Table 1). The study participants were predominantly women (77.6%), with a mean age of 36.2 (SD 11.4), and a median age of 33 years (range 19–68). The mean age of professional nurses was 45.0 years (SD 11.9), while allied health professionals had a mean age of 28.8 (SD 6.9). Nurses constituted the largest group of study participants (51.9%) and the overwhelming majority were South African (94.8%). A quarter of all study participants worked at central hospitals (25.1%) (Table 1). The mean years worked at any of the selected facilities was 6.8 years (SD 8.4) (Table 1).

Health care provider reported discrimination or differential treatment

Of the health care providers surveyed, 19.2% reported that they had witnessed discrimination and 20.0% reported that they witnessed differential treatment of migrants in their work settings (Fig 1). Medical doctors reported witnessing discrimination (31.4%) or differential treatment (31.4%) more frequently than other categories of health professionals (Fig 1). The difference between medical doctors and the other professional groups combined was statistically significant for witnessing discrimination ($x^2 = 9.89$, $p = 0.005$), but not statistically significant for witnessing differential treatment ($x^2 = 4.35$, $p = 0.05$).

Social exclusionary views or practices

Table 2 shows health care providers' mean scores for social exclusionary views or practices, for all providers combined and by socio-demographic and employment characteristics. The items are scored from 1 (strongly disagree) to 7 (strongly agree) so the mean scores should be interpreted in comparison to a score of 4, the midpoint of the scale. Items are arranged in the table with the three positively worded statements on the left and four negatively worded statements on the right.

Positively-worded statements. Providers obtained an overall mean score (M) of 4.4 for the item on being sensitive to the health care needs of migrants and refugees, indicating slightly more agreement than disagreement. Groups reporting lower scores for this item, included: the age category of 45–54 years (M 3.8; SD 1.8); enrolled nurses and nursing assistants (M 3.7; SD 1.6) and those working in a health care facility for a period of 5–9 years (M 3.8; SD 2.0). Conversely, providers born outside of South Africa (M 6.5; SD 0.8); medical doctors (M 5.5; SD 2.1) and allied health professionals (M 5.1; SD 3.1) had higher than average scores.

The highest level of agreement was obtained for the item on providing the same quality of care to migrants and refugees as to South Africans, with an overall mean score of 6.1 (SD 1.5). The lowest mean scores were reported from participants in the age categories 35–44 years (M 5.8; SD 1.6) and 45–54 years (M 5.9; SD 1.5); those who were single (M 5.8; SD 1.9); and

Table 1. Demographic and employment characteristics of survey participants.

Variable	n	%
Age mean (SD)	36.2 (11.4)	
Age by category of health care professional mean (SD)		
Professional nurses	45.0 (11.9)	
Enrolled nurses and nursing assistants	38.3 (9.6)	
Medical doctors	30.8 (7.1)	
Allied health professionals	28.8 (6.9)	
All participants	36.2 (11.4)	
Age group (years)		
< 25	42	15.4
25–34	109	40.0
35–44	55	20.1
45–54	35	12.8
55+	32	11.7
Gender		
Female	215	77.6
Male	62	22.4
Place of birth		
South Africa	254	94.8
Outside South Africa	14	5.2
Marital status		
Single	124	44.8
Living together	25	9.0
Married	108	40.0
Divorced/ Widowed	20	7.2
Category of health care professional		
Nurses:		
Enrolled nurses	30	10.8
Nursing assistants	33	11.9
Professional nurses	81	29.2
All categories of nurses	144	51.9
Medical doctors	70	25.3
Allied health professionals:		
Clinical associate	1	0.4
Social workers	2	0.7
Dieticians/ Dietician assistants	9	3.2
Pharmacists/ Pharmacist interns/ Pharmacist assistants	24	8.7
Radiographers	6	2.2
Rehabilitation therapists (audiologists, speech therapists)	5	1.8
All categories of allied health professionals	47	17.0
Type of health care facility		
Central hospital	72	25.1
Clinic	27	5.0
Community health centre	24	8.7
District hospital	36	13.0
Regional hospital	65	23.5
Regional Tertiary hospital	51	18.4
Specialised Mother & Child hospital	15	5.4

(*Continued*)

Table 1. (Continued)

Variable	n	%
Years worked in facility mean (SD)	6.8 (8.4)	
Years worked in facility median (range)	3 (0.08–39)	
Years worked in facility		
< 2 years	82	29.6
2–4 years	81	29.2
5–9 years	57	20.6
10–14 years	20	7.2
15+ years	37	13.4

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enrolled nurses/ nursing assistants (M 5.8; SD 1.3). Providers working in a health care facility for periods between 10 and 14 years (M 5.7; SD 1.1) and periods of more than 15 years (M 5.9; SD 1.5) also had lower mean scores.

Overall, the providers disagreed with migrants and refugees should be covered by the NHI, as indicated by a mean score of 3.4 (SD 2.0). Providers aged 45–54 years (M 2.8; SD 1.7), allied health professionals (M 2.7; SD 2.6), and those working in the facility for 10–14 years (M 2.8; SD 1.8) were more opposed to this proposal. The highest agreement score was obtained for providers born outside of South Africa (M 5.2; SD 2.1).

Negatively-worded statements. Overall, providers strongly disagreed that they discriminated against migrant and refugee patients, with a mean score of 1.7 (SD 1.1) (Table 2). Providers under 25 years disagreed most with this statement (M 1.1; SD 0.4), while those working in a health care facility for between 10–14 years disagreed least (M 2.3; SD 1.0), indicating relatively less and more exclusionary attitudes respectively.

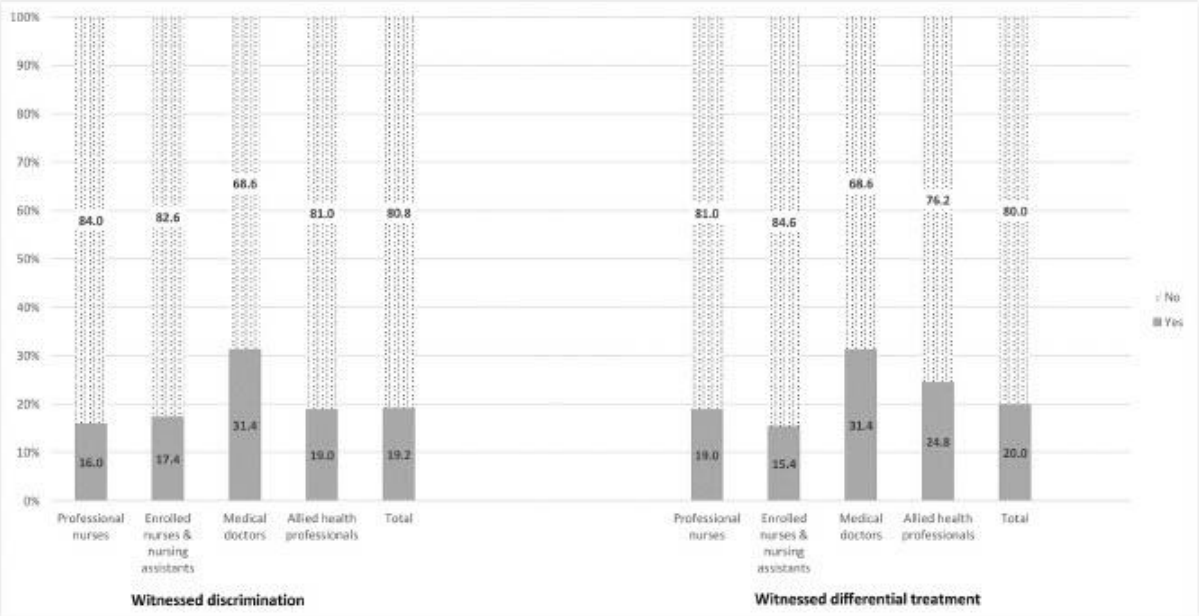


Fig 1. Witnessed discrimination or differential treatment in workplace.

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Table 2. Providers' mean scores (out of 7) of social exclusionary views or practices by socio-demographic and employment characteristics.

		I am sensitive to the health care needs of migrants and refugees	I provide the same quality of care to migrants and refugees as I do to South Africans	I believe migrants and refugees should be covered under the NHI	I discriminate against migrant and refugee patients	I have delayed health care to patients because of their migrant or refugee status	I believe migrant and refugee patients should go back to their home country for health care	I believe that migrant and refugee patients only come to South Africa for health care services
Variable		Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Total		4.4 (2.1)	6.1 (1.5)	3.4 (2.0)	1.7 (1.1)	1.7 (1.2)	3.4 (2.1)	3.6 (2.1)
Gender	Male	4.5 (2.1)	6.0 (1.8)	4.0 (2.2)	1.5 (1.0)	1.5 (1.2)	2.6 (1.9)	3.1 (2.2)
	Female	4.4 (2.1)	6.1 (1.4)	3.3 (2.0)	1.7 (1.1)	1.7 (1.2)	3.6 (2.1)	4.1 (2.1)
Age Group	< 25 years	4.9 (2.7)	6.7 (0.7)	4.0 (2.7)	1.1 (0.4)	1.3 (1.0)	2.7 (2.5)	3.7 (2.3)
	25–34 years	4.5 (2.0)	6.1 (1.6)	3.7 (2.1)	1.7 (1.3)	1.6 (1.1)	3.3 (2.1)	3.5 (2.4)
	35–44 years	4.2 (2.1)	5.8 (1.6)	3.4 (2.0)	1.7 (0.7)	1.5 (0.6)	3.2 (2.1)	4.1 (2.0)
	45–54 years	3.8 (1.8)	5.9 (1.5)	2.8 (1.7)	2.0 (1.0)	2.0 (1.2)	3.7 (2.0)	4.5 (1.8)
	55+ years	4.7 (1.8)	6.2 (1.1)	3.4 (1.7)	1.7 (0.8)	2.2 (1.5)	4.0 (1.7)	4.0 (2.0)
Origin	Born in South Africa	4.3 (2.0)	6.1 (1.5)	3.3 (2.0)	1.7 (1.1)	1.7 (1.2)	3.5 (2.1)	4.0 (2.2)
	Born outside South Africa	6.5 (0.8)	6.0 (2.2)	5.2 (2.1)	1.3 (0.5)	1.2 (0.5)	1.4 (1.6)	2.6 (2.2)
Marital Status	Single	4.2 (2.2)	5.8 (1.9)	3.2 (1.9)	1.7 (1.0)	1.7 (1.3)	3.5 (2.2)	4.2 (2.3)
	Living together	4.5 (1.8)	6.5 (0.9)	4.0 (2.3)	1.6 (1.1)	1.5 (0.6)	3.3 (2.0)	3.3 (1.9)
	Married	4.5 (2.2)	6.3 (1.2)	3.8 (2.2)	1.6 (0.9)	1.8 (1.3)	3.2 (2.2)	3.8 (2.2)
	Divorced/ Widowed	4.2 (1.7)	6.0 (1.2)	3.4 (1.7)	2.0 (1.0)	1.8 (1.0)	3.7 (1.8)	2.6 (1.6)
HCP Category	Professional nurse	4.5 (1.9)	6.1 (1.4)	4.3 (2.0)	1.6 (0.8)	1.7 (1.1)	3.8 (2.0)	4.3 (1.9)
	Enrolled nurse/ Nursing assistant	3.7 (1.6)	5.8 (1.3)	4.0 (1.7)	2.0 (1.0)	2.0 (1.0)	3.4 (1.6)	3.9 (1.7)
	Medical doctor	5.5 (2.1)	6.4 (1.5)	3.4 (2.4)	1.3 (0.9)	1.3 (0.9)	2.7 (2.3)	3.4 (2.4)
	Allied health professional	5.1 (3.1)	6.6 (1.4)	2.7 (2.6)	1.3 (1.0)	1.3 (1.2)	2.5 (2.8)	2.6 (2.6)
Type of facility	Tertiary hospital	4.2 (2.1)	6.0 (1.6)	4.1 (2.3)	1.8 (1.1)	2.0 (1.5)	3.6 (2.2)	3.2 (2.1)
	Regional hospital	4.5 (2.2)	6.0 (1.3)	3.8 (2.1)	1.8 (1.2)	1.6 (0.8)	3.0 (2.0)	3.5 (2.0)
	District hospital	4.2 (1.8)	6.4 (0.5)	3.4 (2.0)	1.4 (0.6)	1.5 (0.9)	3.2 (1.9)	3.9 (2.1)
	PHC facilities	5.0 (2.1)	6.0 (2.0)	3.8 (2.1)	1.3 (0.6)	1.4 (1.0)	3.6 (2.2)	3.8 (1.8)
Years working at facility	< 2 years	5.1 (2.3)	6.0 (2.3)	3.8 (2.6)	1.4 (1.2)	1.4 (1.1)	3.1 (2.7)	3.5 (2.5)
	2–4 years	4.6 (2.0)	6.3 (1.1)	3.5 (2.0)	1.6 (1.2)	1.5 (1.0)	3.0 (2.0)	3.5 (2.2)
	5–9 years	3.8 (2.0)	6.1 (1.3)	3.7 (2.0)	1.7 (0.8)	1.8 (1.1)	3.4 (1.9)	4.4 (2.0)
	10–14 years	4.4 (1.6)	5.7 (1.1)	2.8 (1.8)	2.3 (1.0)	2.0 (1.0)	4.6 (1.9)	4.5 (1.9)
	15+ years	4.4 (1.6)	5.9 (1.5)	3.0 (1.5)	1.7 (0.9)	2.0 (1.3)	3.7 (1.8)	4.0 (1.8)

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Providers also disagreed that they delayed health care to patients because of their migration status with an overall mean score of 1.7 (SD 1.2) (Table 2). The highest mean score for this item was 2.2 (SD 1.5) obtained from providers in the age category of 55 years and older, which

would still be interpreted as general disagreement with the statement (compared to the cutoff of 4), although they did disagree less than other groups.

Overall, providers agreed more that migrants and refugees should return to their home country for health care obtaining a mean score of 3.4 (SD 2.1) for that item. Lower mean scores were obtained for: male participants (M 2.6; SD 1.9); those younger than 25 years old (M 2.7; SD 2.5), those born outside of South Africa (M 1.4; SD 1.6); medical doctors (M 2.7; SD 2.3) and allied health professionals (M 2.5; SD 2.8).

Providers obtained an overall mean score of 3.60 (SD 2.1) for the item on migrants and refugees only coming to South Africa for health care services. Providers born outside South Africa (M 2.6; SD 2.2) and allied health professionals (M 2.6; SD 2.6) agreed least with this statement; while professional nurses actually agreed with it on average (M 4.3; SD 1.9).

Predictors of social exclusionary views or practices among health care providers

Table 3 shows the results of the multiple regression analyses on the predictors of social exclusionary views or practices among health care providers. A negative co-efficient on the positively worded statements (first three) and a positive co-efficient on the negatively worded statements (last four) indicate relatively more exclusionary views (Table 3).

Participants born outside of South Africa had a significantly higher score ($p<0.001$) than those born in South Africa on being sensitive to the health care needs of migrant and refugee patients, indicative of less exclusionary views. Enrolled nurses and nursing assistants had a significantly lower score ($p<0.001$) than the reference category of allied health professionals on being sensitive to the health care needs of migrant and refugee patients, indicating more exclusionary views.

In relation to providing the same quality of care to migrant and refugee patients, participants aged 35–44 years ($p = 0.04$) held significantly more exclusionary views than the under 25 reference group, while enrolled nurses and nursing assistants ($p = 0.01$) were more exclusionary than allied professionals. With regard to the inclusion of migrants under the NHI, single participants had significantly lower mean scores ($p = 0.01$) than the married reference group, suggesting relatively more exclusionary views with regard to NHI coverage. Gender, age, category of health care professional, and years worked in health care facility were no longer significant contributors in the regression analysis for this item.

Providers aged 25–34 years ($p = 0.01$), 55 years and older ($p = 0.004$), enrolled nurses and nursing assistants ($p = 0.01$), and providers working in the health care facility for a period of between 10–14 years ($p = 0.02$) were significantly more likely than the reference groups to indicate agreement with having discriminated against migrant patients. In contrast, providers working in district hospitals and PHC facilities compared to tertiary hospitals agreed less with having discriminated against migrant patients ($p = 0.02$).

Category of health care professional and type of health care facility were predictors of participants' views on delaying care because of migration status. In particular, enrolled nurses and nursing assistants had a significantly higher score than allied health professionals indicating higher agreement that they had delayed care because of migration status ($p = 0.03$). On the other hand, participants from regional hospitals ($p<0.001$), district hospitals ($p = 0.01$) and PHC facilities ($p<0.001$) agreed less that they had delayed care than those from tertiary hospitals.

With regard to the view that migrants and refugees should return to their home country for health services, gender, category of health care professional, and place of birth were significant predictors. Female participants scored higher than men ($p = 0.005$), while professional nurses

Table 3. Predictors of social exclusionary views or practices among health care providers.

Variable		I am sensitive to the health care needs of migrants and refugees		I provide the same quality of care to migrants and refugees as I do to South Africans		I believe migrants and refugees should be covered under the NHI		I discriminate against migrant and refugee patients		I have delayed health care to patients because of their migrant or refugee status		I believe migrant and refugee patients should go back to their home country for health care		I believe that migrant and refugee patients only come to South Africa for health care or services	
		β	p-value	β	p-value	β	p-value	β	p-value	β	p-value	β	p-value	β	p-value
Gender	Reference: Male														
	Female	-	-	-	-	-0.65	0.18	0.15	0.37	0.09	0.73	0.95	0.005*	0.87	0.03*
Age Group	Reference: < 25 years														
	25–34 years	0.27	0.49	-0.50	0.08	-0.32	0.28	0.46	0.01*	0.04	0.83	0.40	0.36	-0.46	0.36
	35–44 years	0.04	0.94	-0.77	0.04*	-0.71	0.12	0.18	0.34	-0.10	0.75	-0.02	0.96	-0.03	0.97
	45–54 years	0.23	0.69	-0.70	0.16	-1.19	0.07	0.48	0.05	0.29	0.50	0.10	0.86	0.40	0.51
	55+ years	1.36	0.16	-0.35	0.38	-0.45	0.51	0.59	0.004*	0.78	0.11	0.55	0.50	0.02	0.98
Marital Status	Reference: Married														
	Single	-	-	0.22	0.56	-0.82	0.01*	-	-	0.00	0.98	-	-	0.69	0.04*
	Living together	-	-	-0.60	0.17	0.01	0.98	-	-	-0.13	0.65	-	-	-0.32	0.45
	Divorced/Widowed	-	-	-0.33	0.46	-0.74	0.23	-	-	-0.25	0.57	-	-	-0.78	0.30
Born in/ out South Africa	Reference: Born in SA														
	Born outside SA	1.58	p<0.001*	-	-	-	-	0.01	0.97	-0.02	0.92	-1.36	p<0.001*	-1.17	0.02*
HCP Category	Reference: Allied health professional														
	Professional nurse	-0.64	0.13	-0.48	0.08	-0.77	0.15	0.00	0.98	0.21	0.32	1.23	0.02*	1.91	p<0.001*
	Enrolled nurses & nursing assistants	-1.32	p<0.001*	-0.73	0.01*	-0.64	0.18	0.54	0.01*	0.49	0.03*	1.13	0.009*	1.42	0.03*
	Medical doctor	-0.13	0.67	-0.19	0.44	-0.56	0.23	-0.08	0.71	0.06	0.78	0.69	0.22	1.65	p<0.001
Type of facility	Reference: Tertiary hospital														
	Regional hospital	-	-	0.10	0.72	-	-	0.01	0.98	-0.40	p<0.001*	-	-	-	-
	District hospital	-	-	0.45	0.06	-	-	-0.46	0.01*	-0.37	0.01*	-	-	-	-
	PHC facility	-	-	-0.00	0.99	-	-	-0.37	0.04*	-0.52	p<0.001*	-	-	-	-
Years working at facility	Reference: < 2 years														
	2–4 years	-0.06	0.81	-	-	-0.21	0.61	-0.08	0.66	-0.07	0.73	-0.55	0.25	0.01	0.98
	5–9 years	-0.46	0.27	-	-	0.41	0.48	-0.10	0.58	0.13	0.74	-0.26	0.65	0.63	0.27
	10–14 years	-0.01	0.98	-	-	-0.31	0.64	0.58	0.02*	0.31	0.40	0.72	0.20	0.45	0.52
	15 or more years	-1.16	0.21	-	-	0.01	0.98	-0.23	0.59	-0.18	0.74	-0.41	0.34	-0.26	0.38
Constant		5.13	p<0.001*	7.26	p<0.001*	5.55	p<0.001*	1.13	0.001*	1.43	0.018*	1.73	0.001*	1.54	0.022*

Only predictor variables statistically significant at 20% in the bivariate analysis were included in the multiple linear regression models. *p<0.05

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(p = 0.02), enrolled nurses and nursing assistants (p = 0.009) had significantly higher scores the allied professional reference group. Providers born outside of South Africa had significantly lower scores than those born in South Africa (p<0.001), indicating less exclusionary views.

Female providers had a significantly higher score than male providers on the view that migrants only come to South Africa for health care services (p = 0.03). Similarly, single participants also held more exclusionary views for this item (p = 0.04), compared to those who were

married or divorced. Professional nurses, ($p<0.001$), enrolled nurses and nursing assistants ($p = 0.03$), and medical doctors ($p<0.001$) had higher scores, indicating agreement with this view on migrants only coming to South Africa for health care.

Discussion

This was the first survey in South Africa, and indeed in Africa, that we know of that quantitatively examined the perspectives of health care providers on public health care services to migrants. Most of the study participants were female (77.6%) and nurses (51.9%). This is not surprising as the majority of health care providers in South Africa are nurses, and women [32]. In 2018, the South African Nursing Council (SANC) statistics showed that 90% of nurses were women [33]. Our study showed that the variables that influenced health care providers' views on social exclusion were gender, marital status, age, category of health care provider, type of facility and years worked in a health care facility (Table 3).

Almost one in five health care providers (19.2%) reported that they had witnessed discrimination, and 20.0% reported that they had witnessed differential treatment of migrants in their work settings (Fig 1). Medical doctors were more likely to report that they had witnessed discrimination of migrant patients in their workplace. A possible explanation for this finding is that medical doctors may be more aware of acts of discrimination against migrants and thus, able to notice such practices when it occurs. Importantly, these findings suggest that medical xenophobia occurs, as described in a previous study in the South African public health system [34]. Studies in other countries have shown variable findings on health care providers' perspectives on discrimination. For example, European studies that examined health care providers' experiences of discrimination found both a reluctance to talk about discrimination, and evidence of discriminatory attitudes towards migrant patients [35, 36]. However, another study in Greece found a more mixed picture of the interactions between providers and migrants, with some providers prioritizing the health care of citizens over migrants, while others provided unrestricted health care access to undocumented migrants despite restrictive laws [37].

In our study, health care providers indicated some sensitivity to the health needs of migrants (mean score 4.4). Providers born outside South Africa expressed greater sensitivity to the needs of migrants. This is not surprising, because these providers are also migrants, and hence identified with migrant patients. In a very different context, a Canadian study found that providers born outside Canada expressed greater cultural sensitivity and were more comfortable with immigrant patients than Canadian-born health providers [38].

Enrolled nurses and nursing assistants in our study had lower scores for sensitivity to the needs of migrants, suggesting that their views were more exclusionary. In South Africa, enrolled nurses undergo two years of training and nursing assistants undergo one year of training. The relatively short training period might be insufficient to instill ethics, values, and culturally responsive health care, which would partly explain these findings. Further research is needed to explore whether the content and length of pre-service training influences views on migrant patients. Studies in Canada and Australia, albeit with physicians, found that cultural barriers hindered the provision of migrant-sensitive health care services [39–41]. Several studies in the same countries have demonstrated that culture-sensitivity training of health care providers can improve the health outcomes of migrant patients [42], through better expressed sensitivity [43, 44], empathy [45] and cultural humility [46]. Although the context of these studies is different from that of South Africa, there would be value in ethics and culture-sensitivity training for all health care providers in the South African public service, with a particular focus on enrolled nurses and nursing assistants.

The pattern of health provider responses was complex and nuanced. For example, although they reported ambivalence on sensitivity to the health care needs of migrants (mean score 4.4), they strongly agreed that they provided the same quality of care to migrants as to South Africans (mean of 6.1). This divergence might suggest that they honor their professional and ethical obligations, even though they may not be that sympathetic to the needs of migrants. More research is needed to explore these apparent differences and contradictions.

Health care providers in our study strongly disagreed that they discriminated against migrants, or delayed care to migrants. Both of these findings are encouraging. However, there were significantly higher mean scores for these two items among enrolled nurses and nursing assistants, indicating more discriminatory attitudes and practices in this group. Other factors associated with discriminating against migrants included providers aged 25–34, older than 55, and working in a health care facility between 10 and 14 years. Conversely, we also found that working in a district hospital and in a PHC facility were predictors of less exclusionary views.

The age variation in discrimination against migrants requires further research. I Health providers in the oldest age category (>55 years) reported more discriminatory views. Another study found that older individuals tend to hold more conservative views [47]. In South Africa, the widespread promotion of human rights has occurred in recent history since the country's democracy, and may have less traction in older generations. The discriminatory attitudes in the younger age groups is more concerning. The findings suggest that legislative changes such as South Africa's Bill of Rights are essential, but do not guarantee changes in attitudes or behaviours. The effect of age on discriminatory views on migrants has also been found in a 2019 survey on social cohesion by the Gauteng City-Region Observatory (GCRO) in South Africa [48]. The study found that participants 55 years and older were more inclined to agree with the view that migrants should be sent home, while respondents between the ages of 25 and 39 years old were more likely to accept/endorse violence against foreigners [48].

The expressed discriminatory views in our study are concerning, as health care providers are required to uphold professional and ethical standards of care [49, 50]. The various health professional Oaths emphasis service to humanity, practicing with conscience, treating all patients with dignity, pursuing justice, and advocating on behalf of vulnerable and disadvantaged patients [51, 52]. A combination of strategies is needed to ensure that migrant-sensitive health services are provided, and that all patients in the Gauteng public health service are treated with respect and dignity, regardless of nationality. These strategies include migrant-inclusive health policies specifically on the entitlements of migrants and health care, advocacy training and campaigns that emphasise the rights and responsibilities of providers, lobbying by civil society organisations, and clear communication about the complaints mechanisms, including the Office of the Health Ombud [53]. There should also be adverse consequences for those health care providers that continue discrimination against migrants, and they should be reported to the relevant health professions council for possible disciplinary action.

The mean score for the item that migrants should return to their home country for health care was 3.4, and that migrants only come to South Africa for health care was 3.6. Female providers, professional nurses and enrolled nurses and nursing assistants had significantly higher agreement than the other categories, again suggesting more social exclusionary perspectives. These views could explain our finding that participants did not agree with the inclusion of migrants and refugees in the proposed NHI scheme (mean score of 3.4). In the regression, single status was the only significant predictor of a more exclusionary view, but it is unclear why this was the case. It is still of concern that most health care providers hold this view, given that they have a critical role to play in the achievement of UHC [54]. Scholars have suggested that health care providers work in constrained conditions, exacerbated by migrant-unfriendly regulatory frameworks, policies and the political rhetoric of government officials that amplify

xenophobic sentiments in South African society [55, 56]. Health care providers may reflect the political rhetoric of xenophobia [57, 58]. This context might explain the social exclusionary views of some of the health workers in our survey. Moreover, agreeing that migrants only come to South Africa for health care may not indicate anti-migrant attitudes, but may reflect the current reality given the virtual collapse of the health systems in their home countries, as in the case in Zimbabwe [59].

The study is cross-sectional and reflects health care providers' perspectives at a point in time. Future research could explore whether and how health care providers' perspectives change over time. The self-reported information obtained from health care providers may be influenced by social desirability bias. However, the self-administered questionnaire using tablets allowed providers to express their views in a confidential manner. The study was only conducted in Gauteng Province, and the findings might not apply to other provinces.

However, there are numerous study strengths. Firstly, this was one of the first surveys that examined the perspectives of health care providers on migrants utilising public health facilities. Secondly, the study quantified social exclusionary attitudes or behaviours and reported discrimination by health care providers against migrant patients, as well as the factors that influence discrimination (e.g. category of health worker). Lastly, the findings provide a baseline for future studies, both quantitative and qualitative, in South Africa as well as in similar low- and middle-income countries. Future research could include a larger sample of health care providers, as well as qualitative research that could provide more depth to the views of different categories of health care providers.

As South Africa moves towards the implementation of the NHI, discrimination and other social exclusionary views or practices of health care providers will undermine progress. The United Nations has called on Member States to put an end to discrimination of migrants in health care settings. There are three key priority areas of action: supporting the rights of both patients and providers; tackling discrimination through evidence and appropriate legal frameworks that ensure accountability; and lastly, collaboration between governments, civil society and communities to address the determinants of discrimination [60]. Health care providers are the foundation of quality UHC. Our study findings indicate that the interaction between providers and migrant patients in Gauteng are complex, and there is no straightforward or single narrative. Given its economic importance, Gauteng should take the lead in implementing the UN recommendations, and should develop more inclusive health policies that are more in consort with the Constitution of South Africa to the benefit of all patients at all levels of care, in support of the achievement of UHC.

Conclusion

Health care providers, specifically medical doctors and nurses, are at the front-line of health care delivery and are thus integral to the provision of migrant-sensitive health care, and the achievement of UHC. Given this criticality, providers' perspectives on social exclusionary views or practices are important in shaping inclusive health policies. Using a lens of social exclusion, we have generated new knowledge on health care provider-migrant interactions in the Gauteng province of South Africa. Social exclusionary views or practices must be addressed at all levels through inclusive health policies, training in culture-sensitivity, ethics and human rights; and promoting health care providers as advocates for migrant patients and their rights.

Supporting information

S1 Questionnaire.
(DOCX)

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CHAPTER 8: DISCUSSION AND RECOMMENDATIONS

8.1 Introduction

Using the theoretical lens of health systems responsiveness (HSR) and social exclusion, the aim of this PhD study was to examine the experiences of international migrants when utilising public health services in the Gauteng Province of South Africa. I achieved this aim through four, inter-related study components: migrant patient survey (quantitative); health worker survey (quantitative); ethnography of the intersection of the health care environment, and the everyday behaviours and practices of health workers and patients (qualitative); and key informants interviews combined with a review of legislation and policies (qualitative).

Since the PhD research was conducted, the global and national context has changed fundamentally due to the COVID-19 pandemic, with millions of confirmed cases and deaths (220). Nonetheless, the notion of a migrant-sensitive health system that includes the "needs of migrants into all aspects of health financing, policy, planning, implementation, and evaluation" (167 ,p.3) remains as relevant as when the PhD research was conceptualised.

In this concluding chapter, I integrate the key study findings (section 8.2) into three inter-related areas of discussion: firstly, migrant patient experiences, HSR and social exclusion; secondly, legislation, health policies, migrants and social exclusion; and lastly, migrant patients and health workers. The recommendations that emerged from the PhD study are presented in Section 8.3. In Section 8.4, the PhD scholarly contribution and policy implications are discussed, while Section 8.5 outlines recommendations for future research.

8.2 Key findings of the PhD study

Table 10 summarises the key findings of this PhD study. The integrated discussion follows below.

Table 10: Summary of the PhD findings

<table>
<tr><th colspan="2">Key informant perspectives and review of legislation/ policies</th></tr>
<tr><td colspan="2">

Paradoxically, legislation and health policies in South Africa both facilitate and exclude health care for migrants.
South African Constitution and the National Health Act facilitate UHC.
Immigration Act and draft 2019 National Health Insurance Bill centre health care access on legal status, thus exclusionary.
Variations in content, interpretation and/or implementation of policies at the provincial level.
Resource constraints in the public health sector contribute to the perceived dysfunctionality of public health care system.
Resource constraints and reported dysfunctionality adversely affect migrant and refugee patients.
Migrants and refugees further disadvantaged by reports and experiences of medical xenophobia.

</td></tr>
<tr><th colspan="2">Survey among 251 migrant patients at 13 public health facilities</th></tr>
<tr><td colspan="2">

94.3% of migrants said the consulting nurse or doctor listened to them.
89.4% said that they received information about condition.
81.7% did not know the name of the consulting nurse or doctor.
30.0% of patients said they waited too long.
Mean patient satisfaction scores with health workers: 7.0 for clerks; 7.7 for security guards, 7.4 for nurses; 8.3 for doctors.
Predictors of migrant patient satisfaction with nurses: information about their condition; polite treatment; time spent at health facility; receiving prescribed medicines.
Qualitative data highlighted challenges of long waiting times and sub-optimal procedures or systems in health facilities.
Migrant narratives of uncaring and discriminatory attitudes of some health workers and communication difficulties.

</td></tr>
<tr><th>Ethnography of health care environment</th><th>Survey among 277 health workers</th></tr>
<tr><td>

Busy, frantic or nervous spaces.
Contestations between patients and health workers, and among health workers.
Presence of migrant patients during busy periods served as detonator for rude or discriminatory remarks, exacerbated by staff shortages and language barriers.
Migrants exercised agency by rebutting or confronting rude health workers; or by leaving health facilities.
Concomitantly, observations of kind and caring health workers upholding their ethical and professional duties to all.

</td><td>

19.2% of health workers reported that they witnessed discrimination against migrants.
20.0% reported that they witnessed differential treatment of migrant patients.
Exclusionary perspectives varied by socio-demographic and employment characteristics, including category of health care provider and the type of health care facility.
Enrolled nurses and nursing assistants held significantly more exclusionary views on: sensitivity to the health care needs of migrant and refugee patients; providing the same quality of care to migrant and refugee patients; discrimination against migrant patients; and delaying care because of migration status.
Providers working in district hospitals and PHC facilities had less exclusionary views compared to those in tertiary hospitals.

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</table>

8.2.1 Migrant patient experiences, HSR and social exclusion

This PhD study set out was to examine the perceptions of migrant patients on HSR, their satisfaction with health workers in 13 randomly selected public health facilities of Gauteng Province (Objective 3), and to observe the everyday practices and behaviours of patients and health workers within these health facilities (Objective 2).

Responsiveness is an essential component of the performance of a health system (74), and by implication for universal health coverage (UHC). Although there is a substantial literature on HSR (74, 182, 186, 188, 190, 221), the concept has received insufficient attention in the context of international migration (222). This PhD study was one of the first studies to combine and adapt the conceptual frameworks of HSR (74) and social exclusion to examine the perspectives of international migrants (142), and to explore the intersection of the health care environment, and the behaviours and practices of both patients and health workers.

The patient survey and ethnography at the 13 health facilities revealed ambiguity in and dissonance of migrants' experiences in the HSR domains of communication and prompt attention.

The majority of patients reported that the attending health worker listened to them (94.3%) and that they received information about their condition (89.4%) (142). These survey findings are encouraging as they suggest positive experiences of the HSR domain of communication. The original WHO discussion document on HSR underscored the need of health workers to communicate with patients to enable them to make autonomous decisions about health services (7).

However, 81.7% of patients surveyed said they did not know the name of the consulting nurse or doctor, while the qualitative patient comments highlighted language difficulties and inadequate communication (142). The ethnographic study (Chapter 5) showed the challenge of insufficient or disrespectful communication to patients in general, but to migrants in particular. On the first day of fieldwork, I witnessed language as an identifier of a migrant, and the health worker threatening to use that knowledge as a tool for social exclusion from

health care. Studies in other countries (217, 223, 224) and in South Africa (63, 125, 225) have also highlighted language barriers and the potential negative consequences for quality of care provided to migrant patients. One South African study recommended free interpretation services and innovative technology-based medical interpretation to overcome language barriers (63). However, the experience in Thailand has demonstrated the lack of sustainability of language interpretation services due to budgetary constraints and lack of legal provisions (178). Furthermore, many health care providers in South Africa are unable to speak the country's indigenous languages, which are enshrined in the Constitution. Hence, there is also need for interpretation services for South African patients who have English language communication difficulties, thereby avoiding the perceptions of preferential treatment of migrants, with resultant resentment and possible xenophobia. Rather, a more comprehensive approach is needed to ensure that HSR and mainstreaming of the health needs of migrants are central aspects of ongoing health sector transformation in South Africa.

This patient survey found that a third of participants indicated that they waited too long, borne out by their qualitative comments (142). This means that the HSR domain of prompt attention (measured by waiting times) was found wanting for this group of patients. The ethnographic study revealed that waiting times were influenced by existing health facility infrastructure, internal hospital systems, teamwork, staff availability and information provided to patients (Chapter 5). The 2010 South African General Household Survey reported that long waiting times were the most common problem among 34.8% of South African adults during their most recent visit to a health care provider (226). This is similar to the finding of long waiting times reported among migrant patients in this PhD study. In South Africa, waiting times is one of the ministerial priority areas, and is a key area for inspection by the Office of Health Standards Compliance (71). Although Gauteng inspected facilities performed better on waiting times in 2019, compared to the other provinces, there remains room for improvement (71).

Interestingly, half of the patients reported that the waiting time was "just right", reflecting the different perceptions of migrant patients (142). The conceptual framework of Mirzoev and Kane posits that the concept of HSR includes people's initial expectations and previous health service interactions or utilisation of health services (74). These initial expectations in

turn are shaped by perceptions of appropriate care, quality and trust, and societal views on health as a human right (74). Hence, one possible explanation is that this group of migrant patients expected to wait much longer than the actual time spent in the health facility. These expectations could be affected by their prior experiences of health care utilisation, whether in their home country or in South Africa. Notwithstanding differences in context, a study in the USA underscored the complex relationship between perceived waiting times, actual waiting times and patient satisfaction (227). The authors found that perceived waiting times rather than the actual time waited predicted patient satisfaction (227). Another study also found that patients' prior expectations influenced their health care satisfaction (228).

Notwithstanding the differences in perceptions on waiting times, this PhD study suggests that waiting times should remain a health ministerial priority, and that the OHSC should continue to inspect and put emphasis on this domain. As shown by the ethnographic study, there are excellent examples of structured and automated patient queueing systems that put responsiveness to patients at the centre of health service delivery (Chapter 5). A potential area for future research might be to determine the critical success factors that enable HSR at health facility level, and the requirements for upscaling such responsiveness to other health facilities in the province.

The PhD study found that clerks obtained the lowest satisfaction mean score of 7.0, while doctors obtained the highest score of 8.3 (142). Nurses obtained a mean score of 7.4. The predictors of migrant patient satisfaction with nurses were closely linked to their perceptions of HSR, notably receipt of information about their condition, polite treatment, waiting time and receiving prescribed medicines. (142). Satisfaction with health workers, including nurses was also associated with a statement on whether migrants would refer the health facility to family or friends (142). A possible explanation for the lower score of nurses compared to doctors is that migrant patients were more likely to interact with nurses, as they are the majority of health care providers in South Africa (229).

The close relationship between migrant patient's satisfaction with health workers and their perceptions of HSR have also been found in studies in the USA, Australia, UK, Israel, Germany, Netherlands, Norway, and Denmark (112, 116). Overall, the mean satisfaction scores obtained in this PhD study suggest that migrants surveyed were relatively happy with the health workers in the selected facilities (142). Studies in USA, Australia, UK, Israel, Germany, Netherlands, Norway, and Denmark have found that migrants expressed low satisfaction with health workers (112, 116, 117). Hence, my PhD study findings could reflect some social desirability bias (230) , despite all efforts to minimise such bias (Chapter 3). Conversely, the study findings might reflect migrants' appreciation of the care received, when compared to health care in their home countries or their previous health service utilisation experiences. It might also reflect the actual provision of quality care, as the OHSC inspection reports illustrate consistent progress over time (71).

Some migrant patients commented qualitatively on discrimination and uncaring attitudes from some health workers (142), and the request for official documentation, prior to health care provision (Chapter 5). The ethnographic observations demonstrated the social exclusionary behaviours of some health care providers, such as rudeness, disrespect, prejudicial views about migrant patients and lack of urgent attention in some emergencies. Numerous studies in other countries have reported on migrants' experiences of gross discrimination during their encounters with health workers (113, 114, 119, 121, 122, 231). Discrimination and social exclusion are also constant themes highlighted in the 2020 World Migration Report (1). Similarly, several qualitative studies among migrant patients in South Africa have underscored experiences of medical xenophobia and discrimination when utilising public health care services (59, 61, 125).

Unfortunately, the patient survey did not include specific questions on migrants' experiences of discrimination and medical xenophobia. This is a study limitation, which requires further research. Nonetheless, the concept of HSR provides a useful mechanism for action in each of the domains, and to ensure that all patients, regardless of citizenship or legal status, experience quality health care (46).

8.2.2 Legislation, health policies, migrants and social exclusion

The experiences of migrant patients are linked inextricably to country-specific legislation, health policies, and the views or actions of key policy actors. Hence, another objective of this PhD was to explore whether legislation, health policies and the perspectives or actions of health policy actors facilitate UHC for migrants, or exacerbate exclusion of migrants (Objective 1). The starting point was an adaptation of the social exclusion conceptual framework, originally developed by the Social Exclusion Knowledge Network (8). Hitherto, the framework has not been used as an analytical tool to explore the intersection of health legislation, policies, social exclusion and the experiences of migrants (232). Exploring the environment of health care provision complements a review of legislation and health policies, as it illustrates both responsiveness and how legislation and policies are interpreted and implemented at the coalface (Objective 2).

The PhD study found that paradoxically, legislation and health policies in South Africa both facilitate and exclude health care for migrants (232). The South African Constitution with its Bill of Rights (31) and the National Health Act (151) facilitate the right to health and UHC. In contrast, the Immigration Act and draft 2019 National Health Insurance Bill are exclusionary, as they centre health care access on the legal status of migrants (232). The language used in the NHI Bill, which refers to undocumented migrants as "illegal migrants or foreigners" (51) is both discriminatory and exclusionary. The aspirational goal of UHC rests upon the principle of inclusivity, particularly of vulnerable groups such as migrants (23, 24). Hence, the NHI Bill requires revisions to ensure UHC for migrants and refugees in South Africa. Additionally, these revisions to the NHI Bill will ensure alignment with the Constitutional values and the country's obligations as a signatory to UN treaties and protocols on the human rights of migrants and refugees.

Many studies in other countries have also stressed the negative relationship between national immigration laws and migrants' legal status on the one hand, and migrants' access to affordable and quality health care (4, 164). Given South Africa's strategic role in the Africa region, the country should demonstrate leadership in its compliance with international

treaties and respect for the human rights of migrants. Ironically, in June 2021, the Global Detention Project highlighted the tightening of restrictions through the Border Control Management Act (233). The review found inadequate health care provision and poor conditions in detention facilities and prisons for undocumented migrants (233). Of particular concern is that that migration is viewed increasingly through the lens of national security and criminality in South Africa (233).

This legislative disjuncture is exacerbated by variations in content, interpretation and/or implementation of policies at the provincial level (232). The lack of a cohesive national framework on migrants and health care means that access to health care varies across the nine provinces. In the PhD research, key informants described the distribution of "guidelines for foreign patients" from a provincial department of health, without the acquiescence of the National Department of Health (232). The intersection of the legislative disjuncture, social exclusion and implementation at facility level was observed first hand while conducting the ethnographic study at 13 health facilities. Firstly, health workers alleged that migrants obtained South African identity documents fraudulently in order to access health services. Secondly, we observed denial of care because of lack of documentation, as the patient visit was not considered an emergency. Another South African study highlighted the negative consequences of the legislative disjuncture between the Constitution and South Africa's immigration laws (107). Alfaro-Velcamp (2017) highlighted that hospital administrators based their decisions on migrants' access to care on their legal status, and perceptions of deservingness to access the limited resources in the public health sector. This notion of deservingness shapes health care access and patient-health worker interactions (170). However, legislation is a structural determinant of health care access, and a potentially powerful tool of exclusion (8).

Both the key informant study (232) and the ethnographic study (Chapter 5) underlined how legislation, health system constraints, the actions of health workers intersect and shape the experiences of migrants when they utilised public health care services. The resource constraints in the public health sector and reported dysfunctionality affect all patients. However, the study found that migrant and refugee patients were exposed to different

dimensions and levels of social exclusion, including experiences of medical xenophobia. The latter includes request for documentation, name-calling, labelling and discrimination, and in some instances, denial of care.

Hence, a comprehensive approach is required to address health system constraints. The 2020 Africa Migration Report has reiterated the importance of investment in migration health, which supports the principles of migrant-sensitive health systems (234). The report emphasises the relationship between migrant-sensitive health system, and "achieving UHC, which is essential for upholding the right to health for all and contributes to social and economic development" (234): page 170.

8.2.3 Migrant patients and health workers

Mirzoev and Kane's conceptual framework posit that peoples' experiences of the health system are shaped by the actions and perceptions health care providers (74). Hence, another objective of this PhD study was to examine the perspectives of health care providers on delivering health services to migrants in Gauteng public health facilities.

In this PhD study, health care providers reported that they had witnessed both discrimination (19.2%) and differential treatment (20.0%) of migrant patients in the facilities they worked in. The ethnographic study demonstrated similar exclusionary behaviours of health care providers. Additionally, exclusionary and less exclusionary perspectives were associated with socio-demographic and employment characteristics factors. In the category of health care provider, enrolled nurses and nursing assistants held significantly more exclusionary views on several items in the survey. There are two possible explanations for this finding. Firstly, the adapted framework posits that there is a broader context which influences the interaction between the people and the health system, consisting of cultural, economic, political and social dimensions (Chapter 3). In Chapter 1, I described the South African context and highlighted the anti-migrant sentiments expressed by policy makers. Mirzoev and Kane posit that policy makers are an integral part of the health systems response because they drive the national health agenda (74) . Hence, health care providers in this study may have echoed the xenophobic attitudes of policy-makers (and broader society). Secondly, another possible

explanation for this finding is that the short period of training that enrolled nurses (two years) and nursing assistants (one year) undergo is insufficient to instill ethics, values and culturally responsive health care. However, this is an area for future research, i.e. to examine pre-service training factors and nursing students' perceptions of the delivery of health care to migrant patients.

Conversely, providers who were born outside South Africa held less exclusionary views on the provision of health care to migrants. These health care providers are migrants and may identify and express solidarity with migrant patients, and therefore hold less exclusionary views. A Canadian study, although with family medicine physicians, demonstrated that providers who were born outside of Canada reported easier encounters and communication with immigration patients, and may identify with immigrant patients having immigrated to Canada themselves (235 ,p.208). The type of facility health care providers were employed at was a factor that influenced less exclusionary views. Health care providers working in district and regional hospitals and PHC facilities were less likely to hold exclusionary views. A possible explanation for this finding is that there may be less exposure to migrants at these facilities, as they seek out higher level facilities such as regional or tertiary hospitals. Further research is required to explore why the type of health care facility influences the views of health care providers on social exclusion.

This PhD study found that the health care environment in which care is delivered is characterised by busy, frantic or nervous spaces and contestations between patients and health workers, and among health workers. Despite the variations in patient profile and numbers, busy spaces and staff shortages at health facilities were a trigger for disparaging and discriminatory remarks towards migrant patients from tense and irritable health workers. Additionally, language barriers also exacerbated these encounters between migrant patients and health care providers.

The findings of my PhD study highlight the need for strategies to prevent discrimination of migrant patients utilising public health services in South Africa. At the same time, the resource constraints, staff shortages and other health system challenges require urgent attention from policy makers. As shown by the ethnographic observations, there were

narratives about migrants overburdening an already constrained public health care system in addition to xenophobic stereotypes about migrant patients. This was also found in the survey among health care providers who were in agreement with the statements that migrants should return to their home country for health care; and that migrants only come to South Africa for health care (141). These findings are similar to those of other surveys that explored opinions towards migrants living in South Africa. The Gauteng City Region Observatory (GCRO) Quality of Life survey (2013) showed that a third of South Africans agreed that migrants should be sent back to their home countries (236). A multi-country study on citizen views about immigrants found that the majority of participants from South Africa (62%) believed that migrants are a burden to the country (237).

The ethnographic observations revealed that there were variations in the number of migrants utilising the 13 public health care facilities, countering the perceptions of "bus loads" of migrants who come to exploit the public health care system. Other researchers have also pointed out that it is a common, yet unfounded narrative that migrants come to South Africa to utilise health care services (47, 238). The narrative about exploitative, dishonest or fraudulent migrants has been found in other studies (208, 209).

In this study, migrants exercised their agency in two ways. Firstly, during certain hostile encounters, migrant patients rebutted or confronted rude health workers. Secondly, when waiting times were too long, migrants exercised their agency by leaving health facilities with the intention of returning to the health facility on another occasion. Thus, migrant patients appear to be active rather than passive actors in the health system, notably in hostile environments and difficult situations. There were no comparable studies on migrant patients and exercising their agency in difficult situations within the South African health care context. However, a study in Sweden found that "patients constantly re-negotiated their agency in potentially abusive situations in the health care system, while reflecting on both their immediate responses and strategies that could protect them and counteract abuse in future (239). The dearth of studies on this topic present an opportunity for future research on the ways in which migrant patients exercise their agency within the health care system.

Simultaneously, my PhD found that many health workers provided services with the utmost professionalism, kindness, caring, and compassion. These qualities among health workers are the foundation of a responsive and respectful health system, and provide a counter-narrative to some of the exclusionary practices and medical xenophobia among health workers. Studies in other contexts have demonstrated that showing kindness was important to a positive health care experience among refugees and asylum seekers, and allowed them to be more confident about their health concerns during the consultation with their health care provider (240, 241). Other studies in South Africa have also shown that health workers use "innovation, creativity, and compromise" (135) and "informal acts of kindness" (123) in the provision of health care services to migrants. Further research is needed on the strategies to advance a culture of caring in the public health system of South Africa.

8.3 Recommendations

There are five categories of recommendations that arise from my PhD study (Table 11): firstly, structural changes, which include legislative revisions and anti-xenophobia campaigns; secondly strategies to enhance health system responsiveness in the Gauteng public health system; thirdly, education and training of health workers; fourthly, information, education and training of migrants; and lastly investment in the public health care system. The responsibilities of different health policy actors are also indicated.

Table 11: PhD Recommendations

Recommendation	Institutional level (e.g. health department)	Civil society	Individuals (e.g. health worker or migrant patient
1. Structural changes: • Revisions to the NHI Bill to remove legal restrictions and exclusionary language • Development and implementation of anti-xenophobia campaigns.	✓	✓	
2. Strategies to enhance health system responsiveness: • Reduce patient waiting times and improve communication at health care facilities.	✓		✓

• Ensure that health care providers wear their name badges.			
3. Education and training of health workers • The health care rights of migrants • Cultural awareness and sensitivity • Ensure that health workers uphold their ethical and professional obligations in health care delivery.	✓		✓
4. Information to and education of migrants: • Health care rights and responsibilities. • Encourage migrants to exercise right to lodge complaints	✓	✓	✓
5. An increased investment in the public health care system.	✓	✓	

8.3.1 Structural changes

In line with my PhD's study conceptual framework (Chapter 3), the first category of recommendations on structural changes includes essential revisions to the NHI Bill to remove legal restrictions and exclusionary language and the development and implementation of anti-xenophobia campaigns.

As highlighted in Chapter 4, NHI Bill needs to be revised to ensure alignment with the values espoused in the Constitution and South Africa's international obligations. During the public participation process on the NHI Bill, numerous individuals and civil society organisations have made submissions to advocate for an NHI Bill that is inclusive of migrants. A joint submission from the SECTION27 and the Treatment Action Campaign (TAC), endorsed by several other civil society organisations in South Africa was made in this regard (242). The submission underscores the issues of population coverage specifically as it relates to migrants, noting the "regression in access to services for asylum seekers, undocumented migrants and their children" (242 ,p.27). Furthermore, the joint submission notes that the NHI Bill provision (in its current form) will be subject to legal challenge on grounds of the right to health enshrined in the Constitution (242). At the time of this write-up, the written submissions on the Bill had closed (29 December 2019) and public hearings were in progress (243). This responsibility rests with the National Department of Health to ensure that the Bill is aligned with the Constitution (31). Ultimately, as the custodian of the NHI Bill, the National Department of

Health should remove the phrase “illegal migrants” and replace it with a non-discriminatory term.

The PhD findings demonstrate the discrimination experienced by many migrant patient, which cannot be seen in isolation of the broader socio-political context. The findings suggest the need for a broader, coalition effort of civil society, government and communities on inclusion and anti-xenophobia. The coalition could draw on the past experience of the Roll Back Xenophobia campaign, with the aim of revitalizing this campaign in an effort to educate citizens on the rights of migrants living in South Africa (244). This campaign would be in support of the South African government’s National Plan of Action to combat Racism, Racial Discrimination, Xenophobia and Related Intolerance 2016-2021 (245). Anti-xenophobia campaigns are not enough to drive change, political will is critical in combatting xenophobia and xenophobic violence in South Africa. Policy makers must condemn xenophobia and xenophobic violence when making statements to the media and when using social media. There should be appropriate sanctions for those who violate their oaths of public office.

8.3.2 Strategies to enhance health system responsiveness

The second set of recommendations centres on strategies to enhance health system responsiveness, for all patients, but migrant patients in particular.

This PhD study found the existence of good practices at some of the study facilities to reduce patient waiting times, and improve communication. For example, one public health care facility had implemented an automated queueing system, with regular communication and close monitoring of patient waiting times (Chapter 5). This illustrates that despite similar constraints as faced by other public health facilities, it was possible to provide responsive care to all patients, including migrants. The Gauteng Department of Health should encourage the sharing of such best practices, which might enable the scaling-up of these to other health care facilities.

The Patient's Rights Charter highlights the right of every patient to know the name of the health care provider (246), while this is aspect is also highlighted by the national core standards (247). Although all health care providers should wear name badges, health care managers do not enforce this requirement. Individual health care provider should be encouraged to wear name badges, introduce themselves to all patients, and health facility managers and the Gauteng National Department of Health should monitor and enforce the wearing of name badges.

8.3.3 Education and training of health workers

The PhD study found that there were excellent examples of caring and compassionate health care providers. Simultaneously, exclusionary perspectives of health care providers varied by socio-demographic and employment characteristics, including category of health care provider and the type of health care facility. The findings suggest the need for pre-service education and training of health workers, and continuing professional development to ensure HSR, and a migrant-sensitive health care system. The criticality of the HRH and quality of care was emphasised by the South African Lancet Commission (46). The Commission underscores the need for awareness campaigns to educate health workers on the health rights and responsibilities of individuals/patients (46).

Hence, a third set of recommendations focuses on the education and training of health workers on the health care rights of migrants and on cultural awareness and sensitivity. This would necessitate a multi-prong approach that involves different health policy actors. Health facility managers should ensure mechanisms to prevent discrimination, such as programmes to educate all health workers about the health care rights of migrants, including refugees. The development of such programmes could be done as a collaborative effort with civil society. Additionally, cultural awareness and sensitivity training should be provided to all health care providers at training institutions.

Although it is the responsibility of individual health care providers to uphold their ethical and professional codes of conduct, managers should reinforce these values. The health

professions councils also play an important role in ensuring that health care providers are aware of the rights of vulnerable groups such as migrants.

8.3.4 Information and education of migrants

As shown in the preceding section, the PhD found that some migrants exercised their agency. The fourth category of recommendation is centered on the individual migrant and their health care rights and responsibilities as users of health care services. The National Health Act (No. 61 of 2003), specifically Chapter 2 outlines the rights and duties of users of health care services (248). Hence, migrants need to be aware of their rights as well as their responsibilities as users of the national health system – these rights and responsibilities are also outlined in the Patient's Rights Charter (246). The responsibility of migrants utilising health care services include for example, to "adhere to the rules of the health establishment", such as not littering and to "treat health care providers and health workers with dignity and respect" (248 ,p.28). Civil society organisations could translate the Patients' Rights Charter into other common regional languages, for example, French (for migrants from Francophone countries).

As users of health care establishments in South Africa, migrants have the right to lodge a complaint and access to redress mechanisms (248). Hence, an individual migrant could exercise agency by lodging a complaint "about the manner in which he or she was treated at a health establishment and have the complaint investigated" (248 ,p.26). The Act includes both private and public establishments as part of this provision. At a practical level, complaints can be lodged through the Office of the Health Ombud in three ways: through an online health service complaint form on the official website of the Office of the Health Ombud; a Whatsapp support line; and an emergency hotline (249). The Office of the Health Ombud performs the duties of protecting and promoting the health and safety of all users of health services, including investigating complaints in the national health system (both private and public establishments) and is established in accordance with the National Health Amendment Act of 2013 (250).

8.3.5 Investment in the public health care system

The final recommendation is around the need for an increased investment in the public health care system to ensure resource availability and sufficient staff numbers. This long-term goal will require political will/leadership and financial stewardship, as enunciated by the South African National Lancet Commission (South African Lancet National Commission, 2019).

8.4 Scholarly contribution

The scholarly contribution of this PhD study is in the generation of new knowledge and its methodological innovation.

8.4.1 Generation of new knowledge

This PhD study has contributed four scientific research papers on the experiences of international migrants in the public health system of Gauteng. The focus and new knowledge generated by each is highlighted below.

- The study on the *intersection of legislation, health policies, the perspectives on key informants and the goal of UHC, inclusive of migrants* demonstrated that there is a legislative disjuncture between South Africa's rights-based Constitution and National Health Act on the one hand, and the Immigration Act and draft 2019 National Health Insurance Bill. This legislative disjuncture is exacerbated by variations in content, interpretation and/or implementation of policies at the provincial level, as well as resource constraints and the behaviours of health policy actors.
- The *survey among migrant patients* on their perceptions of HSR and their satisfaction with health workers was one of the first representative quantitative studies in Gauteng, South Africa. The study generated new knowledge on migrants' perceptions of the HSR domains, their satisfaction with health workers, and the socio-demographic and HSR factors that influenced their satisfaction with health workers.
- The *survey among health care providers* on migrants utilising public health facilities elicited their views on a range of items that served as proxies for social exclusionary views or practices. The study generated new knowledge on discrimination of and differential care provided to migrants, as well as social exclusionary views of health care providers. Exclusionary perspectives varied across different socio-demographic characteristics and

by employment characteristics, including category of health care provider and the type of health care facility.

- The *ethnographic study on the health care environment, the everyday practices and behaviours of health workers and patients in health care facilities* in Gauteng Province, South Africa generated new knowledge on HSR, social exclusion and the influence of the environment on the delivery of care within these facilities.

8.4.2 Methodological innovation

The methodological innovation of this PhD derives from the use of various theories and the mixed methods approach. The latter included in-depth interviews with key informants, a review of legislation and policy documents, surveys among migrant patients and health care providers respectively, and ethnographic observation at 13 selected facilities. This enabled the researcher to examine the health service utilisation experiences of international migrants from different perspectives, and to triangulate the methods and the results. The specific methodological contribution is outlined below:

Adaptation and application of novel theories to the PhD sub-studies:

- Using an adapted social exclusion model of the SEKN as an analytic lens, I explored legislation, policies and the perspectives of health policy actors on migrants and UHC in South Africa through key informant interviews and a document review. The adapted social exclusion model informed both the design of the interview schedule and the thematic analysis of the documents and the data from the key informant interviews.
- I drew on the notion of HSR and social exclusion conceptual framework system to inform the survey among patients. This enabled the examination of their perspectives on HSR and the factors that influence these perceptions.
- I drew on the SEKN social exclusion conceptual framework to inform the survey among health care providers. This allowed for the examination of social exclusion in the health system through the perspectives of health care providers on migrants, who are at risk of social exclusion.
- Using the combined conceptual frameworks of HSR and social exclusion, I explored the environment in which care is delivered through ethnographic observations at 13 health care facilities.

8.5 Policy relevance

There is a global recognition that no one should be left behind in efforts towards UHC. This PhD examined HSR and social exclusion among migrants utilising public health services in Gauteng province, South Africa. The findings of this PhD study reveal the complexities of their experiences (Table 10), and present an opportunity for improving health care for migrants in South Africa, particularly through its contribution to shaping policies that are migrant-aware. These improvements have the potential to benefit all patients utilising the public health care system in South Africa. There is also an opportunity to address medical xenophobia through a multi-pronged approach which involves all health policy actors, including migrants.

Engagement with policy makers and other health policy actors began at the conceptualisation stage of the PhD journey. In 2014, a breakaway session on social exclusion and UHC was included in a workshop on Supporting Health Systems Transformation in South Africa, held at the School of Public Health, University of the Witwatersrand. The objectives of this session was: to identify key research questions on social exclusion and UHC; to provide inputs on case studies and/or study setting; and to identify key factors that will enhance or constrain the execution of the research agenda. The breakaway session had two guest speakers who represented the Jesuit Refugee Services and a large central hospital. They presented perspectives on the needs of migrants and refugees, the constraints in the health system and mediating different expectations from stakeholders. The session was well attended by health policy makers and managers, academics, and civil society organisation. The robust discussions and inputs from the delegates contributed to the research agenda for the PhD study.

The World Migration Report 2020 and the Africa Migration Report 2020 from the IOM are important contributions to the literature on migrants and migration (1, 34). As part of policy engagement, I have corresponded with the IOM contact persons in Geneva and Addis Ababa and sent them the three PhD publications (141, 142, 232), with a note to that the findings from my PhD study may contribute to the 2022 migration report.

Additionally, I have sent the three publications to the network of policy makers, facility managers, hospital executive administrators, and members from civil society and academia who participated in the study – thus taking active steps to influence policy. Lastly, I plan to

engage with the national and provincial departments of health on the findings from my PhD study after the examination process.

8.6 Recommendations for future research

There are a few areas for further research, listed here:

- This PhD study was conducted in Gauteng Province, South Africa. Future studies could replicate this study in other provinces or in other LMICs.
- As South Africa progresses towards the NHI, there is an opportunity to explore the evolution of the NHI legislation and policy development on migrants and refugees using the health component of the IOM's Migration Integration Policy Index.
- In LMICs, legislation and policies on migrants and UHC are complex and contested. Hence, there would be value in undertaking a comparative analysis of legislation and policies on migrants and UHC in South Africa and other countries with a similar income level.
- A qualitative study to explore the ways in which migrant patients exercise their agency during difficult health service encounters.
- A comparative study among migrant patients and South Africans to examine their perspectives on HSR, using different methodologies, including longitudinal studies.
- Using an adapted stigma and discrimination scale, a study among migrant patients to determine their experiences of medical xenophobia and other forms of discrimination.
- There are several other vulnerable groups who are at risk of exclusion, e.g. homeless people, members of the LGBTQI+ community, people living with HIV, and the disabled. A comparison of the experiences of migrants and refugees and other vulnerable groups, whether by geographical location, or health condition, and/or sexual orientation.
- Research among lower categories of health care workers to explore and analyse their perspectives on international migrants, and issues of discrimination, prejudice and othering.
- In South Africa, civil society organisations play a key role in promoting and protecting the rights of migrants and refugees. Thus, an exploration of the role of civil society in

mediating access to health care for migrants in South Africa would provider an understanding of their role in advocating for the rights of migrants and refugees.

8.7 Conclusion

This PhD examined HSR and social exclusion among migrants utilising public health services in Gauteng Province, South Africa. The scholarly contribution is both in the generation of new knowledge and in its methodological approach. The experiences of migrant patients cannot be seen in isolation of legislation, policies, the environment of care provision, their own actions, and the behaviours and actions of health workers.

South Africa has a duty to protect migrants, and refugees, including their health. The findings highlight the need for migrant-inclusive policies as part of South Africa's progress towards UHC, while at the same time emphasising the need for a greater investment in the public health system and improving the responsiveness of the health system. These improvements will benefit all patients utilising public health services, including migrants. At the same time, the findings of health workers who uphold their duties to patients give hope and provide an opportunity to advance the notion of a migrant-friendly public health care system in Gauteng. Given the importance of Gauteng, such advances will also contribute to South Africa's vision of UHC.

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ANNEXURES

Annexure 1: Key informant interview schedule



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

Key Informant (KI) interview schedule

Location:	**Date of interview:**
Position:	
Result codes 01 = Completed 02 = Respondent not available 03 = Respondent refused	 04 = Partially completed 05 = Other

GENERAL

1. Could you tell me a little bit about your experiences or interactions with refugees or migrants?
2. What kind of work or research on migrants or refugees are you involved in?
3. Are you familiar with the distinction between migrants and refugees?

SECTION 1: SOCIAL EXCLUSION AND HEALTHCARE ACCESS

4. Could you comment on healthcare access of migrants or refugees in the public health system in South Africa?
5. In your opinion, what are the factors that influence migrant or refugee access to health care?
6. What are the relationships between citizenship (or lack thereof) and the envisaged national health insurance?
7. Could you share with us your views on the concept of social exclusion?
8. In your opinion, do migrants or refugees experience any form of social exclusion in the public health services? (Probes: If yes, could you give examples of forms of social exclusion they experience? If no, could you explain you answer)

9. Who are the actors (stakeholders) that drive exclusion or inequities in healthcare access for migrants or refugees?
10. What are the relational processes that work to exclude migrants or refugees from the public health system, both at:
    a. Macro-level (e.g. legislation or policies)
    b. Micro-level (e.g. income, social networks)

SECTION 2: POLICIES, PROGRAMMES, ACTIONS TO ADDRESS EXCLUSIONARY PROCESSES

11. In your opinion, what policies or programmes should be put in place to address exclusionary processes faced by migrants or refugees in the public health system?
12. Do you know of any draft policies or programmes in progress that specifically address the healthcare needs of migrants and refugees? If yes, are you able to talk more about it?
13. How should the NHI address the health care needs of migrants and refugees?
14. Could you comment on NHI as opposed to universal health coverage?
15. Any other comments on migrants or refugees, access to health care or universal health coverage?

END OF INTERVIEW SCHEDULE

Annexure 2: Observation checklist



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

ETHNOGRAPHIC OBSERVATIONS GUIDE

Observations of the healthcare setting, activities and people. Here you will be required to write down what you see in the facility, including the interactions between health workers and patients/people.

These include (but are not limited to):

Physical environment	What is the size of the waiting room? Are there chairs? Are there enough chairs? Is there water available for people to drink? Is the waiting room clean?
Patients	Who is sitting (men, women, South Africans, non-South Africans, old, young, pregnant?)? Who is standing? Are people who appear sick being attended to?
Health workers	Do you see any security guards in the waiting room? If so, where are they in the waiting room? What are they doing? Do you see any clerks? What are they doing? Where are they? Do you see any nurses? Where are they? What are they doing? Do you see any doctors? Where are they? What are they doing? Do you see other categories of health care providers? Where are they? What are they doing?
Atmosphere	Is the atmosphere in the room calm? Is the atmosphere in the room tense? Is it busy in the room? Is it frantic? Yes or no?

Annexure 3: Migrant patients semi-structure questionnaire/survey

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

CODE:

EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

STATEMENT OF CONSENT

I have been given the information sheet on the project entitled: Examining health systems responsiveness and social exclusion among migrants and refugees utilising Gauteng public health services: Implications for universal health coverage. I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that it is up to me whether or not I would like to participate in the study and that there will be no negative consequences if I decide not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the process at any time.

I understand that the researcher/ PhD student involved in this study will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that comments that I make will not be reported back to anybody else. I consent voluntarily to participate in this study. I have been given telephone numbers that I may call if we have any questions or concerns about the research

1.	Having read and understood the information sheet, do you wish to participate in the study?	○ Yes ○ No
2.	Please indicate the health care facility (HCF) for this field visit:	○ HCF 1 ○ HCF 2 ○ HCF 3 ○ HCF 4 ○ HCF 5 ○ HCF 6 ○ HCF 7 ○ HCF 8 ○ HCF 9 ○ HCF 10 ○ HCF 11 ○ HCF 12 ○ HCF 13
3.	Date of field visit	
4.	Age	_____ (in years)
5.	Gender	○ Female ○ Male
6.	Country of origin	
7.	Highest education qualification	

8.	Number of years living in South Africa	
9.	What is your marital status?	○ Married ○ Living together ○ Single ○ Divorced/ separated ○ Widowed

Section 2: Questions to be asked when patient has finished consultation and is exiting the facility

1.	Would you say the amount of time you spent for your visit today was:	○ Too much ○ Just right ○ Too short ○ Other
2.	Do you think the nurse or doctor listened to you?	○ Yes ○ No
3.	Do you know the name of the nurse or doctor who attended to you?	○ Yes ○ No
4.	Do you think your privacy was respected?	○ Yes ○ No
5.	Were you given information about your condition?	○ Yes ○ No
6.	Were you given any of the medicines prescribed for you?	○ Yes ○ No
7.	Were you treated politely?	○ Yes ○ No
8.	If your friend or relative was sick would you encourage them to come to this facility?	○ Yes ○ No

Section 3: Patients comments. Please provide your opinion on the following questions.

1.	What do you think about your clinic or hospital visit today?
2.	What advice or suggestions of you have for facility staff?

Section 4. Finally, please indicated how you feel about the service you received from facility staff today on the scale from 1 (extremely unhappy) to 9 (extremely happy) below. If an item is not relevant to you, please indicate not applicable (N/A).

1.	Nurses	○ Extremely unhappy ○ Very unhappy ○ Moderately unhappy ○ Slightly unhappy ○ Neither unhappy nor happy ○ Slightly happy ○ Moderately happy ○ Very happy ○ Extremely happy
2.	Doctors	○ Extremely unhappy ○ Very unhappy ○ Moderately unhappy ○ Slightly unhappy ○ Neither unhappy nor happy ○ Slightly happy ○ Moderately happy ○ Very happy ○ Extremely happy
3.	Clerks	○ Extremely unhappy ○ Very unhappy ○ Moderately unhappy

	○ Slightly unhappy ○ Neither unhappy nor happy ○ Slightly happy ○ Moderately happy ○ Very happy ○ Extremely happy
4. Security guards	○ Extremely unhappy ○ Very unhappy ○ Moderately unhappy ○ Slightly unhappy ○ Neither unhappy nor happy ○ Slightly happy ○ Moderately happy ○ Very happy ○ Extremely happy

END OF SURVEY

Annexure 4: Migrant patient information sheet



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

MIGRANT PATIENT INFORMATION SHEET

Introduction

Good day. My name is Janine White. I am a PhD student in the School of Public Health at the University of the Witwatersrand in Johannesburg.

Why are we doing the study?

We are doing a study to find out about the health care experiences of migrants and refugees at this public health facility. We hope that the information obtained from the study will contribute to create better healthcare services for migrants and refugees.

How will we do the study?

If you agree to participate in the study, I will ask you a few questions about your marital status, age, education, country of origin and number of years in South Africa. You do not have to tell me your name, and I will not ask you about your legal status in South Africa. I would also like to ask you to complete a questionnaire on your views of health systems responsiveness, in addition to asking about your health care experience once your consultation with the provider is done.

Please note that I cannot assist you with any aspect of the care you receive at this facility.

How do I know that the information I give will be kept confidential?

Your responses will be kept confidential and will be used for the purpose of this study only. Your responses will be treated as private and confidential. information from you and other participants will be written in a report. We will not use your or any other participants' names in the report.

Did you get permission to carry out the study?

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committee and the Gauteng Department of Health.

Will there be any benefits from participating?

There will be no direct benefits to anyone who participates in the study. Participation in this study is voluntary. Similarly there will be no negative consequences for individuals who do not want to be accompanied or interviewed. You will not be compensated for taking part in the study.

What are my rights?

You do have the right to refuse participation. You can stop participation in the study at any time. You have the right to decline to answer any questions that makes you feel uncomfortable. You do not have to give reasons and it will not affect the services you receive at the health facility.

Will there be any harm from participating?

We do not foresee any risks to you taking part in the research apart from taking up your time. If you feel upset or uncomfortable during the study, you can stop at any time.

Who do I contact if I want to ask more questions?

This research has been approved by the University of the Witwatersrand Research Ethics Committee. If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the chair of the research ethics committee, Professor Clement Penny on (011) 4883820. If you have questions about the research, you may also contact the researcher/ PhD student: Janine White Phone: 083 330 9395, or my supervisor Professor Laetitia Rispel on (011) 717 2043.

Annexure 5: Self-administered questionnaire – health care providers



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

Thank you for taking the time to participate in this study. Your participation is invaluable!

1. Having read and understood the information sheet, do you agree to participate in the study?	○ Yes ○ No
2. Please indicate the health care facility (HCF) for this field visit:	○ HCF 1 ○ HCF 2 ○ HCF 3 ○ HCF 4 ○ HCF 5 ○ HCF 6 ○ HCF 7 ○ HCF 8 ○ HCF 9 ○ HCF 10 ○ HCF 11 ○ HCF 12 ○ HCF 13
3. Date of field visit	
Section 1: Background Characteristics	
4. How old are you? (in completed years)	_____
5. What is your sex?	○ Male ○ Female
6. Category of health professional	○ Professional nurse ○ Enrolled nurse ○ Nursing assistant ○ Doctor ○ Other
7. How many years have you been working at this facility?	
8. The country of your birth?	
9. What is your current marital status?	○ Married ○ Living together ○ Single ○ Divorced/ separated ○ Widowed
Section 2: Perceptions on social exclusion health systems responsiveness and universal health coverage	
9. In this past year, have you seen incidents of discrimination against migrants and/or refugees in this facility?	○ Yes ○ No

10. In your opinion, are migrants and refugees treated differently in this facility compared to South Africans?	○ Yes ○ No
Listed below are questions on migrants and refugees. Please indicate how strongly you would agree or disagree with each statement by selecting the corresponding number. Please indicate a response for each statement – do not leave any out.	
11. I am sensitive to the health care needs of migrants and refugees.	○ Strongly disagree ○ Disagree ○ Disagree slightly ○ Neither disagree nor agree ○ Agee slightly ○ Agree ○ Strongly agree
12. I provide the same quality of care to migrants and refugees as I do to South Africans.	○ Strongly disagree ○ Disagree ○ Disagree slightly ○ Neither disagree nor agree ○ Agee slightly ○ Agree ○ Strongly agree
13. I believe migrants and refugees should be covered under the NHI.	○ Strongly disagree ○ Disagree ○ Disagree slightly ○ Neither disagree nor agree ○ Agee slightly ○ Agree ○ Strongly agree
14. I discriminate against migrant and refugee patients.	○ Strongly disagree ○ Disagree ○ Disagree slightly ○ Neither disagree nor agree ○ Agee slightly ○ Agree ○ Strongly agree
15. I have delayed health care to patients because of their migrant or refugee status.	○ Strongly disagree ○ Disagree ○ Disagree slightly ○ Neither disagree nor agree ○ Agee slightly ○ Agree ○ Strongly agree
16. I believe migrant and refugee patients should go back to their home country for health care	○ Strongly disagree ○ Disagree ○ Disagree slightly ○ Neither disagree nor agree ○ Agee slightly ○ Agree ○ Strongly agree
17. I believe that migrant and refugee patients only come to South Africa for health care services	○ Strongly disagree ○ Disagree ○ Disagree slightly ○ Neither disagree nor agree ○ Agee slightly ○ Agree ○ Strongly agree

Annexure 6: Health care provider information sheet



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

HEALTH CARE PROVIDER INFORMATION SHEET

Introduction

Good day. My name is Janine White. I am a researcher and PhD student in the School of Public Health at the University of the Witwatersrand in Johannesburg. As part of my PhD studies, I am conducting research on migrants and refugees using health care facilities in Gauteng, South Africa. I request your participation in this study because you are a health care provider who has daily contact with migrants and refugees seeking health care at this facility.

How will we do the study?

If you agree, participation in this study involves taking part in completing a self-administered questionnaire. The questionnaire will take approximately 10 – 15 minutes to complete. The questionnaire requests information about: your background characteristics; the health care utilisation of migrants and refugees in this facility; your perceptions on social exclusion, practices and universal health coverage and your views on health systems responsiveness. We will use a series of vignettes, which are stories about patients utilising health care services, to elicit your views on health systems responsiveness. We want you to think about these people's experiences as though they were patients in this facility. Once you have read each story, you will be asked to rate your response on a scale from 0 (very good) to 5 (very bad). The questions are not a test, so there is no right or wrong answer.

How do I know that the information I give will be kept confidential?

You are not required to provide any identifiers for example, your name when you complete the questionnaire and all completed questionnaires will be assigned a code. All questionnaires will be kept in a locked cupboard in my office at Wits. Only my supervisor and I will have access to the completed questionnaires.

Did you get permission to carry out the study?

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committee and the Gauteng Department of Health.

Will there be any benefits from participating?

There will be no direct benefits to anyone who participates in the study. Participation in this study is voluntary. Similarly there will be no negative consequences for individuals who do not want to be accompanied or interviewed. You will not be compensated for taking part in the study.

What are my rights?

We would like you to participate in the study. You do have the right to refuse participation. You can stop participation in the study at any time. You have the right to decline to answer any questions that you do not wish to answer.

Will there be any harm from participating?

We do not foresee any risks to you taking part in the research apart from taking up your time. If you feel upset or uncomfortable during the study, you can stop at any time.

Who do I contact if I want to ask more questions?

This study has been approved by the University of the Witwatersrand Research Ethics Committee. If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the chair of the research ethics committee, Professor Clement Penny on (011) 488 3820. If you have questions about the study, you may also contact me: Janine White (phone: **083 330 9395)** or my supervisor, Professor Laetitia Rispel on 011 717 2043.

Appendix 7: HREC (MEDICAL) clearance certificate

R14/49 Janine Anthea White

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170988

NAME: (Principal Investigator)	Janine Anthea White
DEPARTMENT:	Public Health Public Health Care Facilities in Gauteng
PROJECT TITLE:	Examining Health Systems Responsivenes and Social Exclusion among Migrants and Refugees Utilising Gauteng Public Health Services: Implications for Universal Health Coverage
DATE CONSIDERED:	Adhoc
DECISION:	Approved unconditionally
CONDITIONS:	Sub-Study under Primary Study M140848
SUPERVISOR:	Prof Laetitia Rispel
APPROVED BY:	Professor P. Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	23/10/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

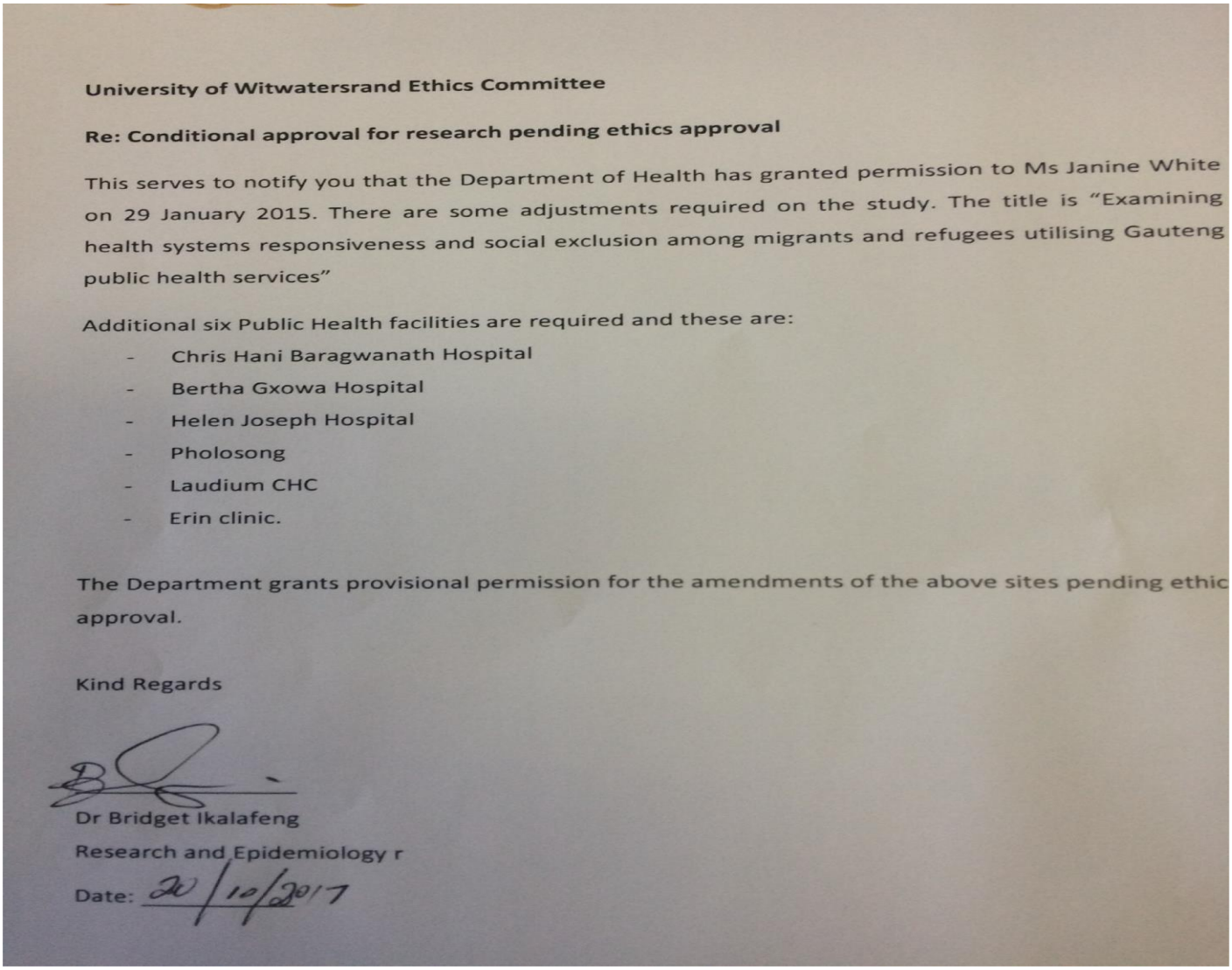
To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially review September and will therefore be due in the month of September each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date 24 October 2017

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 8: Gauteng Department of Health permission



University of Witwatersrand Ethics Committee

Re: Conditional approval for research pending ethics approval

This serves to notify you that the Department of Health has granted permission to Ms Janine White on 29 January 2015. There are some adjustments required on the study. The title is "Examining health systems responsiveness and social exclusion among migrants and refugees utilising Gauteng public health services"

Additional six Public Health facilities are required and these are:

- Chris Hani Baragwanath Hospital
- Bertha Gxowa Hospital
- Helen Joseph Hospital
- Pholosong
- Laudium CHC
- Erin clinic.

The Department grants provisional permission for the amendments of the above sites pending ethic approval.

Kind Regards

Dr Bridget Ikalafeng
Research and Epidemiology r
Date: 20/10/2017

Annexure 9: Key informant information sheet



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

INFORMATION SHEET FOR KEY INFORMANTS

Introduction and background

Good Day. My name is Janine White. I am a PhD student in the School of Public Health at the University of the Witwatersrand.

I am doing a study to examine the characteristics and processes of social exclusion experienced by migrants and refugees in the utilisation of health care services in Gauteng. I am interested in the relationship between citizenship, universal coverage and the proposed NHI. I kindly request your participation as a key informant because you are a health leader or practitioner, a researcher or expert on social exclusion or a health rights advocate.

The interview will last for about 45 minutes. If you agree to take part, I will ask you questions about: social exclusion, the experience of migrants and refugees in relation to health care access or utilisation; factors that influence refugee and migrant access to quality healthcare; strategies on how social exclusion could be tackled at both policy and programmatic levels; and the relationship between citizenship or non-citizenship and the envisaged NHI.

The questions are not a test, so there is no right or wrong answer. My role as an interviewer is to listen and to respect your point of view. You may refuse to answer any questions that you do not feel comfortable answering. You may also say that you do not know the answer to a question.

Confidentiality

The information that you provide during the interview will be kept confidential. Only my supervisor and I will know who has been interviewed. All interviewees will be assigned a code and these codes will be used on the transcribed interviews. These codes will only be known to my supervisor and me. We undertake that all information provided by you will be used only for the purpose of the study. Everything that you say when answering the questions will be treated as private and confidential. This means that apart from the person who asks you the questions, no one will know how you answered. Your name will not be revealed in any written data or report resulting from the study. The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up in my PhD thesis.

Consent

Permission to carry out this project was sought from the University of the Witwatersrand Research Ethics Committee (Medical). I will ask you to sign an informed consent form, both to participate in the study and to record the interview. If you are willing to give your consent and take part, we will appreciate your participation and the information that you are willing to provide.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the interviews. Similarly

there will be no negative consequences for individuals who do not want to be interviewed. Also note that you will not be compensated for taking part in the study. During the interview, you have the right to decline to answer any questions that make you feel uncomfortable, or to stop the interview at any time. However, I would appreciate it if you openly share your thoughts and feelings about the questions I will be asking you.

Recording the interview

I would like to request your permission to audiotape the interview because I cannot write down all your answers quickly enough and might miss some important things that you will say in response to some of the questions that you will be asked if we do not record them. It is essential for you to know that the tapes and notes will remain confidential and your identity will not be disclosed. The tape will be listened to by my supervisor and me at the School of Public Health whose offices are located in Johannesburg. Tapes of interviews will be transcribed and transcripts of interviews will bear the code and not the name of the interviewee. The information will then be coded and written up as part of my PhD thesis.

Contact details

I will be happy to answer any question you have about this study. This PhD study has been approved by the University of the Witwatersrand Research Ethics Committee. If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the chair of the ethics committee, Professor Clement Penny on (011) 7171234. If you have questions about the research, you may also contact my supervisor or me.

Researcher/ PhD student: Janine White
School of Public Health
University of the Witwatersrand, Johannesburg
Telephone: 011717 2259
Email: Janine.white@wits.ac.za

Supervisor: Professor Laetitia Rispel
School of Public Health
University of the Witwatersrand, Johannesburg
Telephone: 0117172043

Annexure 10 : Key informant consent form to participate in the interview



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

CONSENT FORM FOR KEY INFORMANT INTERVIEW

I have been given the information sheet on the study entitled: *Examining health systems responsiveness and social exclusion among migrants and refugees utilising Gauteng public health services: Implications for universal health coverage.* I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that it is up to me whether or not I would like to participate in the interview and that there will be no negative consequences if I decide not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researcher/PhD student involved in this study will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that comments that I make will not be reported back to anybody else. I consent voluntarily to participate in the interview for this study. I have been given telephone numbers that I may call if we have any questions or concerns about the research.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Annexure 11: Key informed consent form for audio recording of the interview



EXAMINING HEALTH SYSTEMS RESPONSIVENESS AND SOCIAL EXCLUSION AMONG MIGRANTS UTILISING GAUTENG PUBLIC HEALTH SERVICES

INFORMED CONSENT FOR AUDIO-RECORDING OF INTERVIEW

I have been given the information sheet on the study entitled: *Examining health systems responsiveness and social exclusion among migrants and refugees utilising Gauteng public health services: Implications for universal health coverage.* I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after the PhD degree is conferred.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at any time.

I consent voluntarily for the researcher/ PhD student to record the interview.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Annexure 12: Adapted distress protocol for survey administration with migrant patients

