Blurred policy spaces and grey areas in-between: Exploring policy responses to cross-border migration and antiretroviral therapy treatment continuity in Johannesburg and Vhembe

Research Report for Master of Arts (MA) by Research in Migration & Displacement Studies

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Declaration

I declare that this dissertation is my own unaided work. It is being submitted for the degree of Master of Arts by Research at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination by any other University.

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Kudakwashe P Vanyoro

Signed on the 14th of March 2017

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Dedication

To mum and dad for your support and to Amanda for always believing in me. You guys rock!

Abstract

Background: Policy responses to communicable diseases and other non-communicable ones in South (ern) Africa have not adequately engaged with mobility. While Southern African Development Community member states have all adopted clear policies and programmes to deal with communicable diseases for their population in South Africa and elsewhere, deliberately, these do not extend to non nationals. In South Africa, there is a perception that many health care workers are not aware of national health policies and legislation that affect their practice, which leads to poor outcomes. But, in reality, a number of polices and guidelines are incomplete or inapplicable to non nationals, making frontline discretion unavoidable.

Objectives: This study mainly sought to understand the practices that frontline health care workers adopt to navigate a space of blurred policy and the "grey areas in-between" (McConnel, 2010), in relation to migration and antiretroviral treatment, using bottom-up policy analysis, namely "street-level bureaucracy" (Lipsky, 2010) as an analytical tool.

Methods: Qualitative methods were used including policy review, literature review, in-depth interviews with frontline health care workers and participant observation.

Findings: Empirical research in Vhembe district and Johannesburg found that in spite of several institutional challenges, health care workers were providing health care services and antiretroviral treatment to various categories of non-nationals reliant on public health care, albeit sometimes with some difficulties. But, the difficulties they faced in providing antiretroviral treatment were policy and systems related, in that, those that had a hard time accessing treatment did so because they were not in possession of identity documents, required referral letters or spoke non-native languages in the absence of translation services. This thesis illustrates the various innovations frontline health care workers employed to address these challenges. It demonstrates that health care workers discretion plays a crucial role in health care delivery, and there is need to recognise the importance of informal elements such as human relationships, communication networks, leadership and motivation towards the

policy function of the country's health system. It concludes that the informal practices of frontline health care workers ought not only to be recognised but also strengthened where possible.

Keywords: *migration, health, HIV/AIDS, policy, South Africa, Vhembe, Johannesburg*

List of Acronyms

ACMS - African Centre for Migration & Society

AIDS - Acquired Immunodeficiency Syndrome

ANC - African National Congress

ANC - Antenatal Care

ART - Antiretroviral Therapy

CD4 - Cluster of Differentiation 4

COJ - City of Johannesburg

CSDH - Commission on Social Determinants of Health

DHS - District Health System

DoH - Department of Health

DRC - Democratic Republic of Congo

FMSP - Forced Migration Studies Programme

GDP - Gross Domestic Product

GP - General Practitioner

HIV - Human Immunodeficiency Virus

HPR - Hospital Perfomance Report

HRW - Human Rights Watch

ID - Identification

IOM - International Organisation for Migration

LSHTM - London School of Hygiene and Tropical Medicine

maHp - Migration and Health Project Southern Africa

MSF - Médecins Sans Frontières or Doctors Without Borders

NGO - Non Governmental Organisation

NHP - National Health Plan

PHC - Primary Health Care

SADC - Southern African Development Community

SANAC - South African National AIDS Council

SDR - Socially Desirable Responding

STI - Sexually Transmitted Infection

TB - Tuberculosis

TEBA - The Employment Bureau of Africa

UNAIDS - Joint United Nations Programme on HIV/AIDS

UNFPA - United Nations Population Fund

UNHCR - United Nations High Commissioner for Refugees

UNICEF - United Nations International Children's Emergency Fund

VCT - Voluntary HIV Counselling and Testing

WHO - World Health Organisation

Preamble

It is my last day of fieldwork in Musina and I am now set to return to Johannesburg. After finishing my meeting at the local municipality offices, I proceed to the taxi rank at about 11:00 am. When I arrive (at about 11:30 am), there are several taxis, some calling for Polokwane-bound passengers to board. I find the one going to Johannesburg; a 22 seater IVECO commuter ominibus. I am only the second person to enter the taxi and it looks far from being filled. The time approaches 1:00 pm now and no one has yet neared to enter or speak to the female conductor writing tickets outside; just opposite the front passenger sit. Finally, a Somali gentleman arrives. But he can barely understand the local language or speak much English for his good. As I observe, I can tell he is trying to have a conversation with the conductor in which it appears he does not have taxi money.

His phone rings and he passes it on to the conductor to talk to the caller. Eventually, the conductor reaches an agreement with the caller who has promised to send the transport money via e-wallet. "Someone must have promised this man a job", I think to myself. Out of procedure, the conductor asks for the gentleman's identity document in order to enter it into the travel manifest. The Somalian pulls out a compeletely torn asylum seeker's permit which certainly looks like it has been washed in his pockets several times. The gentleman finally enters the taxi and sits next to me. When the taxi eventually fills up (at about 4: 30 pm), we depart. As we approach Johannesburg 5 hours later, the Somali gentleman's phone rings again and he randomly asks me to talk to the caller. Out of politeness, I comply. The man on the phone asks me to assist the Somali gentleman by showing him where to get taxis that go to Pietmaritzburg. "He is your brother", he says to me.

(Field notes, Vhembe, 09-11-2016).

Chapter One: Introduction

1.1 Rationale for the study

Assuming the Somali migrant in the preamble is living with human immunodeficiency virus (HIV) and temporarily staying in Musina searching for work, and a better opportunity arises in Pietmaritzburg, would he have told the person on the phone he was living with HIV and needed treatment? What would a torn asylum permit mean for access to treatment in a clinic? Moreover, what does it mean to be somewhere where one does not speak local languages and needs to access treatment? The preamble helps to illustrate the precarity of many cross-border migrants living in South Africa arising from the confluence of two politically challenging concerns: being a non-national and health.

These simple analogies demonstrate the everyday life experiences affecting continuity of care and treatment adherence for HIV for crosss-border migrants. As Sargent and Larchanche (2011: 346) argue, when migrants move, they not only move across geographical borders, "but also across, between, and among medical systems". Therefore, comprehending how continuity of HIV care is instituted and practised across, between and among internal and regional medical systems requires a thorough study of the actors that provide health care services.

Some studies have done this. Extant studies of migration and health in South Africa have inadvertently prompted a parochial understanding of health care workers as actors that practice "medical xenophobia" (see Zihindula et al., 2015; Crush and Tawodzera, 2011; Misago, et al., 2010; Human Rights Watch (HRW), 2009; Landau, 2007; Pursell, 2005; Nkosi, 2004).

But, the reality is not as simple as that. All who are reliant on the public system experience challenges (Vearey, 2008; 2012; 2014; 2016), even though some challenges are perhaps more specific to non-nationals (HRW, 2009). Therefore, some studies do not outrightly support this view (Pophiwa, 2010; Makandwa, 2014; Vearey et al., 2016; Hunter-Adams and Rother, 2017).

This ambivalence in the literature prompted this study. It incorporates the acknowledged gap in clear policy, standardised guidelines and systems of patient referral to harmonise and better coordinate HIV treatment (antiretroviral treatment (ART)) in the Southern African Development Community (SADC) region (SADC, 2009; Walls et al., 2016; Vearey et al., unpublished) into existing migration and health scholarship (SADC, 2009; Walls et al., 2016; Vearey et al., 2016; Vearey et al., unpublished); using this policy lens to explore discretion on the frontline of health care service provision. Responding to this gap, and prompted by research undertaken by the African Centre for Migration & Society (ACMS) since 2008, including a more recent study done in partnership with the London School of Hygiene and Tropical Medicine (LSHTM) in 2015 in Johannesburg and Vhembe, this study explores the practices, experiences and perspectives of frontline public primary health care (PHC) service workers providing ART services. The focus on health care providers was a point of entry to explore the above ambivalences because of the dearth in voices of frontline health care staff who actually deal with migrants; particularly in a context of policy gaps. Until now, some scholars had considered provider discretion through the lens of street level bureacracy (Walker and Gilson, 2004; Moyo, 2010), but few in instances of blurred policy and "grey areas in-between" (see McConnel, 2010).

The study findings show that non-nationals who are undocumented, non-native speaking or without referral letters present manifold difficulties to health care workers. This results in a counterintuitive response; the stereotyping of non-nationals to blame them for their "indigency" (Lipsky, 2010) through "social imaginations" (Larkan et al. 2010) of the "problematic" patient (Moyo, 2010), simultaneously accompanied by innovation and creativity on the frontline to assist, which results in some form of bureaucratic incorporation (Marrow, 2012) and - to a certain extent - therapeutic citizenship (Nguyen et al., 2007; Wilhelm-Solomon, 2013).

1.2 Background to the study

Southern Africa is characterised by mixed migration flows and composed of livelihoods seeking and forced migration (Landau and Segatti, 2009; Vearey, 2012; IOM, 2013). Declining economies, armed conflict and political uncertainty have contributed to migration becoming a key strategy for people to safeguard themselves

and their families, enabling them to improve their livelihoods and safety (Conway and Cohen, 1998; MacCarthy et al., 2009; Kankonde, 2010). Globally, migration is now a way of life for many, as an estimated 3.3% of the world's population has crossed a border (Weine and Kashuba, 2012; United Nations Population Fund(UNFPA), 2015). Reflecting global trends, an estimated 3.3% of South Africa's population was born outside of the country (Statistics South Africa (Stats SA), 2011). This is also consistent with an analysis of national census and community survey data suggesting that there are approximately 1.6 million cross-border migrants in South Africa (Vearey, 2012; Stats SA, 2015).

In this context, health is a key asset for migrants who are often individuated to move through positive selection. Migration and health are therefore interrelated (Evans, 1987; Gushulak and MacPherson, 2006) in interesting yet complex ways. Policy-makers and planners are recognising that migration is a key social determinant of health (MacPherson and Gushulak, 2001) and a key structural driver of HIV (Zuma et al., 2003; Karim et al., 2013).

But migration in South(ern) Africa is rarely well managed and responses are inadequate (Fonn, 2011; Walls et al., 2016; Vearey et al., 2016). At a regional level, the SADC Framework for the Control of Population Mobility and Communicable Diseases, originally drafted in 2009 (Vearey, 2014), attempts to create harmonious systems for continuity of care. However, South Africa has not yet approved or ratified this document (Vearey, 2014; Vearey et al., forthcoming). Suffice it to say, there is a lack of nationally and regionally co-ordinated strategies to ensure treatment continuity for chronic conditions as a result (Vearey, 2014). Inadequate regional harmonisation and coordination lead to sub-optimal cross-border patient referral services (Vearey et al., forthcoming).

One of the ways in which migration may drive HIV is that, if not properly managed, as existing literature suggests is currenty the case, it is a social process that may adversely affect adherence rates and differentials among mobile populations or expose them to a potentially higher risk of infection (through poor housing, family separation, risky sexual behaviour etc.) (Coffee, 2007; Crush et al., 2010; Goudge and Ngoma, 2011; Munyewende et al., 2011; Murray et al., 2011; Weine and Kashuba,

2012: 1605; Colebunders and Kenyon, 2015). However, it is also important to acknowledge that non-nationals have also been found to adhere better to HIV treatment than locals (McCarthy et al., 2009).

ART treatment forms an important component of any strategy to support people living with HIV and manage the disease (Harries et al., 2001). It stops the virus from replicating (Harries et al., 2001; Lewthwaite and Wilkins, 2009; Joint United Nations Programme on HIV/AIDS (UNAIDS), 2015). However, ART can only be effective through life long adherence which helps to prevent the development of resistant strains (Goudge and Ngoma, 2011: 52).

Barriers to adherence for HIV treatment include food insecurity, stigma, isolation from family, gendered conflict and economic dependence, all of which may be created or compounded by mobility (Vearey, 2008; International Organisation for Migration (IOM), 2005; Crush et al., 2010). But, an understanding of the structural barriers that impact on adherence remains limited (Goudge and Ngoma, 2011). Morevover, the influence of a lack of ART treatment harmonisation policies, systems and structures across the SADC region in a context of recognised, ongoing population mobility – within and between countries - has not been comprehensively studied even though some literature call for this (Walls et al., 2016; Vearey et al., 2016; Vearey et al., forthcoming).

Responding to this gap, and prompted by research undertaken by the African Centre for Migration & Society (ACMS) since 2008, including a more recent study done in partnership with the London School of Hygiene and Tropical Medicine (LSHTM) in 2015 in Johannesburg and Vhembe, this study explores the practices, experiences and perspectives of frontline public primary health care (PHC) service workers providing ART services. It is mainly concerned with understanding the practices that frontline health care workers adopt to navigate a space of blurred policy and the "grey areas in-between" (McConnel, 2010), in relation to migration and ART, using bottom-up policy analysis, namely "street-level bureaucracy" (Lipsky, 2010) as an analytical tool. While McConnel (2010) uses the concept of policy "grey areas in-between" to reconcile the dichotomies of policy failure-success in evalutaion, thereby providing a

middle ground, in this study, it is used to describe the space in which policy either does not exist or is unclear to health care workers.

Inter alia, it surfaced in the earlier ACMS and LSHTM study that health care workers were adopting innovative responses to facilitate access to treatment for local and foreign patients with limited resources (staffing, linguistic, policy, guidelines, medication etc.) (Vearey et al., 2016). The study acknowledged that this phenomenon needed to be better understood through further research.

In meeting its objective, this study deals with additional methodological and conceptual concerns. First, it responds to existing calls for migration and health studies that move beyond methodological nationalism: "the assumption that the nation/state/society is the natural social and political form of the modern world" therefore different national groupings ought to be studied individually (Wimmer and Schiller, 2003: 302; Madhavan and Landau, 2011; Myroniuk and Vearey, 2014; Vearey et al., 2016). This approach assumes an "apparent naturalness and givenness of a world divided into societies along the lines of nation-states" thus the analysis does not rely on explicit reference to larger social entities (Wimmer and Schiller, 2003: 303-304).

Second, this study problematises the currency of migration and health scholarship that has tended to focus on the experiences and perspectives of foreign patients; prompting some scholars to accentuate "medical xenophobia" (Zihindula et al., 2015; Crush and Tawodzera, 2011; Misago, et al., 2010; HRW, 2009; Landau, 2007; Pursell, 2005; Nkosi, 2004). Medical xenophobia is described as "the negative attitudes and practices of health sector professionals and employees towards refugees and migrants on the job" (Crush and Tawodzera, 2011: 1). Meanwhile, for Zihindula et al. (2015: 2) it is, "any practice, judgment or behavior that creates and strengthens oppressive relations or conditions that marginalize, exclude and/or confine the lives of refugees". These studies often suggest negative discretion on the part of health care workers in public PHC service delivery without exploring their other responses. Indeed, while there may be some critical problems with provider attitudes towards non-nationals, these need to be explored in a more nuanced way (Andersen, 2004).

This study aims to counters this bias by acknowledging that, indeed, at worst, frontline health care workers may "give in to favoritism, stereotyping, convenience, and routinising", all of which serve their own agency or purposes (Lipsky, 2010: xiv). But, as already argued by Lipsky (2010: xiv), "at best, street-level bureaucrats invent modes of mass processing that more or less permit them to deal with the public fairly, appropriately, and thoughtfully". As a modus-operandi, frontline health care workers have been found to often adopt so-called "processes of making do, tinkering, and ad-libbing" (Livingston, 2012: 21) in "conditions of great uncertainty" (Livingston, 2012: 8). But this is often assumed to be about ways of working that negatively affect cross-border patients rather than exploring ways of helping patients. Therefore, this study concurs with Vearey et al. (2016) who have found that frontline health care workers may also provide benefits to non-nationals by adopting certain innovative practices.

The study's objectives are met using (deliberative) bottom-up policy analysis (Young and Gaunt, 2014; Portillo and Rudes, 2014; Henderson and Pandey, 2013; Hoyle, 2013; Finlay and Sandall, 2009; Hajer and Wagenaar, 2003; Walker and Gilson, 2004; Walt, 1994) since current policy analysis concerned with migration and the heath care system has tended to be dominated by top-down approaches, which have failed to provide adequate explanations of frontline agency (Walt et al., 2008). Few studies have paid attention to the influence of health care workers on migration and health policy in South Africa (Walker and Gilson, 2004; Moyo, 2010). This can indeed be achieved through an introspection of "their attitudes to migrants and refugees, knowledge of migrant patient rights and rationale for their behaviours towards migrants" (Crush and Tawodzera, 2011: 29).

1.3 The research sites

Fieldwork for this study was conducted at two public PHC clinics: one in the cross-border Musina sub-district of the Vhembe District and one in the urban Johannesburg Metropolitan Municipality.

The Vhembe district lies on the northern border of the Limpopo province, where it borders Botswana, Zimbabwe and Mozambique. Vhembe is composed of four local municipalities that correspond to the four Vhembe health sub-districts; Musina, Makhado, Mutale and Thulamela (Massynn et al., 2015). A population of 1 294 723, high unemployment and poverty levels make seeking health care more difficult (Massyn et al., 2015). Vhembe has one regional hospital, six district hospitals and 146 primary health care facilities. Because the district borders on Botswana, Zimbabwe and Mozambique, public PHC facilities in certain areas face challenges of treating foreign nationals from sorrounding border areas, who are a part of the border population but are "not included in the headcount, in addition to the local population" (Massyn et al., 2015: vi). This does not imply that these non-nationals necessarily move for healthcare. Headcount is normally used to determine the amount of resources that must be allocated to each clinic, but low headcount in relation to actual population is not only influenced by the exclusion of non-nationals, or internal migrants alone but also problematic ways of applying census data.

The City of Johannesburg (COJ) has a population of approximately 4,434,827 (Stats SA, 2011; COJ, 2012). The city lies at the heart of the Gauteng province, which receives one of the largest number of internal and cross-border migrants in South Africa (Stats SA, 2014). COJ faces many challenges in terms of urban poverty, inequality, social exclusion and underdevelopment (COJ, 2012) that all negatively affect social determinants of health, including risky sexual behaviour (see Weine and Kashuba, 2012) and access to public PHC. The city also recognises that HIV/AIDS has a devastating effect on the social and economic development of the city's population (COJ, 2012). According to Leggett (2003) (cited by Landau, 2007) close to a quarter of Johannesburg inner-city residents were born outside South Africa, yet Gauteng as a province is largely dominated by internal migration (86%) (Landau and Gindrey, 2008). Johannesburg is home to 37% of the province's six municialities; the highest (Landau and Gindrey, 2008). Johannesburg is one of the many cities that are unable to draw on established data about their own citizenries and face even more acute difficulties in estimating the number of non-nationals in the cities. Therefore, as Landau and Gindrey (2008) suggest, in the absence of sound data, myths about migration and mobility continue to inform policy decisions most of the time;

including health care and other service delivery. In other words, urban growth is poorly managed.

1.4 Research question and objectives

Overall, this study aimed to address the folllowing research question:

> What are the practices, experiences and perspectives of frontline health care workers in urban and cross-border public PHC facilities associated with high levels of migration?

The study was concerned with meeting the following three main objectives:

i. Understanding the practices that frontline health care workers adopt to navigate a space of blurred policy and the "grey areas in-between" (McConnel, 2010), in relation to migration and ART, using bottom-up policy analysis, namely "street-level bureaucracy" (Lipsky, 2010) as an analytical tool;
ii. Comparing the experiences of these actors across urban and cross-border public PHC facilities associated with high levels of migration; and
iii. Infering the various meanings attached to the lack of any official state policy that harmonises ART treatment for non-nationals, from the perspectives and experiences of frontline health care workers.

1.5 Structure of the research report

This report is divided into five chapters. Chapter One introduces the study's rationale and its background, describes and justifies the research sites and explains its research question and objectives. Chapter Two explores the prominent debates shaping the discourse of migration, health, policy and health care systems in the South African, regional and global literature and presents the conceptual framework. It then presents a discussion that identifies the existing gaps in this scholarship in order to qualify the need for carrying out this study. Chapter Three presents the methods used and

provides justification for their suitablity, while acknowledging their strengths and weaknesses. Chapter Four presents the sample, its professional characteristics and the key research findings thematically. A discussion of the findings in the light of existing literature is then pursued, in order to assess the study's contribution to current scholarship. Finally, Chapter Five consolidates the key findings into policy and academic recommendations and conclusions; setting an agenda for future research and action.

Chapter Two: Literature Review

2.1 Introduction: Setting the scene

This chapter explores prominent debates, identified in the literature review, shaping the discourse of migration, health, policy and health care systems in the South African, regional and global literature and presents a conceptual framework. It then pursues a discussion that identifies existing gaps in this scholarship to qualify the need for carrying out this study.

Understanding health care issues in South Africa requires a historical appraisal of the role apartheid played in contributing to health inequality; particularly the oppressive labour regime which mainly operated through population mobility (see Coovadia et al., 2009). Using such an approach, three interrelated issues that were affected even until today emerge: Black people's health and well being, health care policy, and health care systems (Coovadia et al., 2009; Jobson, 2015). Through exclusionary policies, health care services were used by the state as, "an instrument of apartheid to uphold the social, economic and political institutions structured along legally defined racial categories" (Walt, 1994: 11). In turn, structural determinants of health in the form of discriminatory social, economic and political institutions had profoundly negative implications on the health and well-being of the country's black majority (Coovadia et al., 2009).

Social and structural determinants of health in this study are understood as "the underlying conditions that result in a range of health outcomes" (Commission on Social Determinants of Health (CSDH), 2007 cited in Vearey, 2008: 362). World Health Organisation's (WHO) definition of social determinants as, "the conditions in which people are born, grow, live, work and age" (UNAIDS, 2015: 43) is also used. Therefore, apartheid can be conceived as one underlying instrument that produced health care policies and systems that resulted in a range of health outomes.

Cross-border and internal migration were and remain a major structural determinant of health. South Africa's long history of intra-regional and internal labour migration towards farms, factories and mines demonstrates an exemplar of the relationship

between migration and health (Evans, 1987; Gushulak and MacPherson, 2006). Through the discovery of diamonds in Kimberley in 1867 and the Witwatersrand gold in 1886, mining became the cornerstone of the country's economy, complemented integrally by manufacturing (Coovadia et al., 2009). With an insatiable demand for cheap black male labour, created by these economic developments and rooted in systematic racial segregation that was facilitated by high foreign direct investment flowing into the economy, recruitment methods became coercive (Coovadia et al., 2009). This allowed the apartheid state to enforce the labour migration of black males from the rural areas to the cities through legislation, taxes, and restricted access to land and other modes of production (Coovadia et al., 2009).

On a regional level, The Employment Bureau of Africa (TEBA) was set up throughout Southern Africa to recruit farm and mine labourers (Wilson, 1972; de Gruchy, 2014). This was a strategy to complement internal labour migration by importing Africans to the South African mines. For example, based on a series of agreements between South Africa and Portugal, the Portuguese government received money for each recruited African, estimated to be two pounds and sixteen shillings for each individual (Serapiao, 1979: 27; Darch, 2011). This was detrimental to African migrants who were never consulted and received lower salaries than South Africans (Serapiao, 1979). This also had disastrous effects on the health of this migrant population. As Mozambican nationalist Mondlane's account fleetingly described:

> Remembering my experience in Mozambique, I cannot recall a single family that does not count the loss of at least one man who either died in the mines of South Africa or came home with an illness contracted in the mines and died a few years later. The death toll between 1902 and 1940 stands at 81 166. (Darch, 2011: 53).

Facilitated by rapid industrialisation, by 1911, South Africa's gold mines had become the major employer of migrant labour in Southern Africa (Mlambo, 2010). Jeeves (1985, cited in Coovadia et al., 2009) shows that, there was a marked increase of mine labourers from 10, 000 in 1889, to 200, 000 in 1910 and 400, 000 in 1940. Coovadia et al. (2009: 817) suggest that this long history of "organised labour regimes", which

were racist, exploitative and economically and politically disempowering to the country's black majority (Vanyoro, 2015) produced negative health structures.

2.2 Institutional legacies: Health and health care systems in South Africa

2.2.1 The health and well-being of black people in South Africa

The study uses the definition of the Alma Ata Declaration (1978) jointly convened by WHO and United Nations Children's Fund (UNICEF) which defines health as, a state of "complete physical, mental and social well-being, and not merely the absence of disease or infirmity". Many disease patterns emerged from the apartheid state's migrant labour regime due to health risks created by squalid living conditions and hazardous mining activities, single-sex living and separation of families; and they negatively affected the health and well-being of black internal and cross-border migrant labourers (Coovadia et al., 2009). The apartheid state's policy of racial segregation had created overcrowded and unsanitary hostels in urban areas occupied by black labourers (Mathee, 2011). Ultimately, these unhealthy living conditions contributed to the spread of communicable diseases by forcing the repatriation of ill labourers who spread tuberculosis to the reserves in the process. Stuckler et al. (2010: 1) and Karim et al. (2013: 921) argue that the rapid spread of Tuberculosis (TB) and the HIV epidemic in the 1980s was facilitated by the system of circular migration between mines and rural homelands.

For some, the failure to contain the HIV/AIDS epidemic in South Africa can be traced to "contextual changes of rapid urbanisation, [and] the continued operation of the migrant labor system" (Zuma et al., 2003; Sanders and Chopra, 2006: 76). Others (Campbell, 1997; Macheke and Campbell, 1998) see it as a result of the living and working conditions in mines that shaped a man's identity and risky sexual practices (Crush et al., 2010; Weine and Kashuba, 2012).

Today migrant labour and gender inequity remain two of the top key drivers of the South African HIV epidemic (Zuma et al., 2003; Karim et al., 2013: 931). For example, it has been argued that a migrant miner's absence from home, a culture of "macho male sexuality" on the mines, the ready availability of "casual and commercial sex", and the constant fear and personal experience of "death and

dismemberment" underground all place miners at high risk of HIV infection (Crush et al., 2010: 3).

According to UNAIDS (2016), in the year end of 2014 there were 36,9 million people living with HIV worldwide. Of these, at the same period, sub-Saharan Africa hosted 25,8 million; a significant 70% of the global HIV infection. Metaphorically speaking, "If TB and HIV are a snake in Southern Africa, the head of the snake is here in South Africa" (Motsoaledi, 2010 cited in Stukler et al., 2010: 1). HIV/AIDS accounts for 31% of the total disability-adjusted life years of the South African population (Coovadia et al., 2009: 817), and the health system has failed to effectively address the disease (Kahn, 2011). This squarely moves us to a discussion of South Africa's health care system.

2.2.2 Overview: South Africa's health care system

Health care is associated with preventive, curative and palliative services and interventions that are delivered to individuals or populations (UNAIDS, 2015: 23). According to UNAIDS (2015: 24), a health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health. In 2009, 64% of the South African population was entirely dependent on the public sector for all their health care services. This figure has since risen to 84% or 42 million people who are dependent on the public health sector for health care services (Jobson, 2015).

The purpose of any health system is to serve and help improve the health of the population (Schaay and Sanders, 2008: vii). The challenge is Sub-Saharan Africa and South Africa is generally characterised by poorly functioning public health systems (Fonn, 2011; Walls et al., 2016). In particular, South Africa's health care system was adversely affected by the policy visions of the apartheid state (Coovadia et al., 2009; Jobson, 2015).

South Africa's health system consists of a large public health sector, a small yet growing private sector and an Non-Governmental Organisation (NGO) sector.

According to Jobson (2015), the public health sector is funded by the state, with 40% of all its health expenditure coming from the National Treasury. South Africa spends more on health than any other African state and many other middle-income countries (Schaay and Sanders, 2008) yet health outcomes are far worse than similar middle-income countries (Jobson, 2015). Relative to the 5% of gross-domestic product (GDP) recommended by WHO for state health expenditure, 11% of the government's total budget is allocated to nine provincial departments (Jobson, 2015).

PHC services, commonly delivered at a clinic, health post or a private practitioner's surgery, are the first line of access for those in need health care services. The approach taken by the South African government on public PHC fits into the so-called PHC model. According to the Alma Ata Declaration (1978, cited by Schaay and Sanders, 2008: 4), PHC is, "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain." PHC aims at responding to people's health needs and demands, to safeguard, promote and restore health (Van Damme et al., 2002: 49). In its ideal form, it should form an integral part of the country's health system and be the first level of contact for individuals, the family and community, bringing health care as close as possible to where people live and work (Schaay and Sanders, 2008).

Specially trained PHC nurses run clinics and community health centres usually have doctors and nurses. Both facilities are meant for patients with common health needs and problems. PHC facilities are free of charge, including for services such as HIV testing and ART medicines. Primary care focuses on personal health or individual health care and is predominantly curative or therapeutic, preventive and rehabilitative (Schaay and Sanders, 2008: 5).

The underdevelopment of the public PHC system in South Africa can be traced back to policies of racial fragmentation and the separation of health care services to provincial and local authorities along curative and preventive lines respectively (Coovadia et al., 2009). The division in the healthcare delivery system was "the outcome of the unjust system over the past 300 years which took responsibility for

providing services primarily to the white minority" (Jobson, 2015: 4). Fragmentation and separation of health care services was exarcebated by the creation of Bantustans or so-called "ethnic homelands", facilitated by the 1913 Natives Land Act, each having their own health department that was systematicaly underfunded (Coovadia et al., 2009). According to Coovadia et al. (2009), by 1994, South Africa had fourteen health departments. Each had a focus on the hospital sector at the financial expense of public PHC services that were severely underdeveloped and catered for different racial groups (black, coloured, Indian and white) (Jobson, 2015). These "semi-autonomous entities" struggled to provide medical and public health care because they were poorly organised, inefficient and often ineffectively managed (Kautzky and Tollman, 2008: 20).

After apartheid, through the 1994 National Health Plan (NHP), health care services were consolidated into one national department which was responsible for national health policy, and nine provincial health departments which were responsible for provincial policy and public health service delivery (Kautzky and Tollman, 2008). The NHP sought to eliminate the fragmentation and duplication of services (Kautzky and Tollman, 2008). It integrated all health services under a single Ministry of Health; decentralised the organisation and management of health services through a well-coordinated district health system; [and] made comprehensive, community-based health care accessible to all South Africans by establishing PHC centres as the foundation of the national health system" (Kautzky and Tollman, 2008: 23). According to Schaay and Sanders (2008), the District Health System (DHS) is a mechanism to implement PHC by better coordinating and organising communities. DHSs were envisaged as, "a focus for decentralisation of political power and resources, and increased democracy and equity" (Schaay and Sanders, 2008: 6). They became the main mechanism for implementation of PHC (Harrison, 2009).

Even though the African National Congress (ANC) government transformed primary health care- a mainly nurse-driven service (Lehmann, 2008)- into the cornerstone of the country's health policy, the failures in health system governance in the post-apartheid period have certainly compounded implementation of PHC (Coovadia et al., 2009). Despite substantially redressing large inequalities among the distribution of infrastructure, financial, human resources and geographical location and levels of

care, the DHS has failed to be properly institutionalised (Harrison, 2009). According to Coovadia et al., (2009: 828) there remains, "confusion and delays incurred in defining the geographical boundaries and governance responsibilities and structures" of the DHS. For example, in Vhembe district, significant efforts to strengthen public health care through the DHS by allocating resources have not achieved needed results (Massyn et al., 2015).

South Africa's public health sector is also hampered by shortages of medical personnel (Jobson, 2015) and what Segatti (2014: 12) refers to as a "general context of a very strained public service seriously affected by under - and inadequate staffing and attrition of staff to the private sector and emigration". Morale among health workers is also low, especially among nurses in PHC facilities (Harrison, 2009). Many black locals remain impoverished and exposed to overcrowding, inadequate sanitation, low wages and malnutrition, against general white affluence (Coovadia et al., 2009). Another major challenge for public health services is the burden of the HIV pandemic with 11.2% of the population of 54.9 million living with the disease (Jobson, 2015). Overall, the country faces a "quadruple burden of disease" (Kahn, 2001; IOM, 2013); a phenomenon that refers to the country's four concurrent epidemics (maternal and child health, HIV/AIDS and tuberculosis, non communicable diseases and injury and violence). This is a health profile found only in the SADC region (Coovadia et al., 2009). An additional burden placed on the country's services by the management of the HIV epidemic (IOM, 2013: 12) impacts negatively on a public health system that itself struggles to ensure adequate services and access for all due to "crisis of care" (Crush and Tawodzera, 2011: 5).

In response, the state introduced the practice of running HIV clinics in 2003 as part of a state funded plan to "roll-out" ARV treatment in the care of HIV-positive patients who do not have access to private medical aid (Anthonissen and Meyer, 2008: 5). At the HIV clinics patients present know their status and require some form of health care (Anthonissen and Meyer, 2008). However, some drug stock-outs have been reported in these clinics.

Because resourcing of the public health sector has remained stagnant compared to substantially increased expenditure in the private sector, there are reasons to believe that this has contributed to the above-mentioned shortages (Coovadia et al., 2009).

The private health care sector, is primarily funded by medical aid scheme subscriptions whose services are provided in 238 private hospitals. There is a huge disparity in expenditure and burden between South Africa's private and public sector. As Harrison (2009: 24) puts it, "a common observation is the disproportionate financing of the private sector, relative to the number of beneficiaries. Almost five times as much is spent on each person on medical aid than on an uninsured person using the public sector." While the public health care sector spends R122.4 billion on 84% of the population, the private sector spends almost the same amount on meagre patients; R120.8 billion annually to cover 16.2% of the population or 8.2 million people (Jobson, 2015). Meanwhile, many NGOs spend about 5.2 billion on HIV and TB interventions (Jobson, 2015).

2.3 Mobility and access to health care

2.3.1 Migration and health context

The concept of a "migrant" is contested, and various definitions in the literature abound (Migration Observatory, 2015). This study's use of the terms cross-border migrants/non-nationals interchangeably is only to capture nationality (Migration Observatory, 2015). Because the study did not interview migrants per se, other criteria like length of stay are not used to define cross-border migrants/non-nationals as these could not be delimited. Deliberately, to avoid suggesting alienness, the study avoids as much as possible using the terminology of "foreign migrants". "Undocumented" is used in the study to describe individuals who currently lack the documentation required to be in South Africa legally (Vearey, 2012: 61).

The Southern African region has mixed migration flows characterised by livelihoods seeking and forced migration (IOM, 2013). An estimated 3,3% of the world's population has crossed a border (Weine and Kashuba, 2012; UNFPA, 2015). This figure does not capture all internal rural-urban migrants who are estimated to constitute 16 million of the world's total population (Weine and Kashuba, 2012). In

2009 there were around 2,2 million migrants in Southern Africa, making up 3,7% of the population (see Landau and Vanyoro, 2015: 1). Results from the analysis of 2011 South Africa Census data revealed that there were 2 173 409 international migrants (4.2% of the 2011 total population) (Stats SA, 2015). South Africa hosts the second highest number of cross-border migrants in Africa (IOM, 2013). These are mostly refugees, asylum seekers and labour migrants from neigbouring countries. According to Stats SA (2011), an estimated 3.3% of the the country's population was born outside of the country. But internal migration is far more significant than international migration (Polzer, 2010; Crush; 2011; Stats SA, 2011b) as an estimated 7% of the total population are internal migrants (Moultrie et al., 2016).

2.3.2 Access to health care services for cross-border migrants/non-nationals

Dominant migration discourses pathologise the "foreign body" as a "disease-carrying threat to the nation state" (Harper and Raman, 2008: 5). This discourse has contributed to the persistence of anti-non-national sentiment and access challenges for non-nationals in South Africa's public health care facilites (Crush and Tawodzera, 2011: 1). Cross-border migrants that rely on the public health care system face challenges in accessing health services (Crush and Tawodzera, 2011; HRW, 2009; Vearey, 2008; Landau, 2007). These are related to unfair charges based on nationality, lack of adequate information, lack of documentation, weak health systems and differing treatment protocols (SADC, 2009).

While experiences in accessing the public health system are challenging for both citizens and non-nationals, "the evidence shows that migrants, including refugees and asylum seekers, experience specific abuses in addition to the systemic failures that affect all patients, compounding the vulnerability they already face" (HRW, 2009: 5). Landau (2007) reports incidences where foreigners had to wait longer and encounter other forms of discrimination, only to be prescribed short courses of prescribed medication upon gaining access (Pursell, 2005; Nkosi, 2004). Outright denial has nonetheless not been reported (Moyo, 2010; Makandwa, 2014; Vearey et al., 2016; Hunter-Adams and Rother, 2017).

Language has also been reported as a challenge for cross-border migrants accessing care in South Africa's public PHC clinics (Makandwa, 2014; Zihindula et al., 2015; Vearey et al., 2016; Hunter-Adams and Rother, 2017). But generally, Zimbabwean Ndebeles have been found to fare better due to the language's close linguistic proximity to Zulu (Siziba, 2015). Language is an important tool for prevention strategies, treatment and counseling of the HIV disease (Peräkylä, 2010). South Africa's multilingual context means that the health care sector is characterised by diversity in terms of language, culture, race, religion and major socio-economic differences (Oostendorp and Bylund, 2012: 78). The nature of the condition and of currently available medication is such that successful verbal communication is an essential precondition to effective treatment (Anthonissen and Meyer, 2008: 1). Language allows patients and care-providers to "make their intentions known" (Anthonissen and Meyer, 2008). This is a crucial step in the process of identifying a problem, investigating how long it has existed, exploring what meaning this problem may have, and setting in action a treatment strategy (Cameron and Williams, 1997: 419).

According to Cameron and Williams (1997: 419), if problems in linguistic encoding interfere with this process, there may be important consequences. A language barrier disarms a communicant's ability to assess meanings, intent, emotions and reactions (Putsch, 1985: 3344). Kaplan et al. (1989) found that more conversation by patients relative to physicians, and more affective exchange between patients and physicians were specific aspects of patient-physician communication associated with better health outcomes (Perez-Stable et al., 1997: 1212).

Previous research indicates the communicative dilemmas and difficulties of doctors and patients in consultations related to ART treatment (Anthonissen and Meyer, 2008). These communicative problems arise from the variety of disparate matters that need to be attended to, specifically the need to monitor constantly the physical condition of patients, their understanding of essential aspects of the disease and their ability to follow the rigid treatment procedures which allows them to be responsible for managing their own condition (Anthonissen and Meyer, 2008: 2).

There are several strategies that may be used to curtail this challenge and bureaucratically incorporate migrants (Kirkham, 2003; Marrow, 2012). Reliance on English and other languages like Afrikaans, as lingua franca and the use of formal or informal interpreters have been found to be paramount in facilitating understanding in South Africa (Oostendorp and Bylund, 2012).

However, while linguistic diversity may appear useful prima facie, it is usually constructed as negative as it can have consequences such as miscommunication, misdiagnosis and lack of access to adequate healthcare (Deumert, 2010). The possibility that linguistic diversity and multilingualism can have positive effects in the context of HIV/AIDS communication has not been seriously investigated (Oostendorp and Bylund, 2012: 78). Therefore, with little empirical data to support their premise, Putsch (1985) and Perez-Stable et al. (1997) go as far as insisting that it is unlikely that even optimal use of interpreters will suffice.

Elsewhere, Derose et al (2009) found that, in the United States (US), foreign-born immigrants were more likely to perceive discrimination in their healthcare experiences and language was one barrier to access health care services. In the United Kingdom (UK), similar experiences also resonate. Feldman (2006: 810) argues that refugees and asylum seekers face challenges in accessing health services "including registration with general practitioners (GPs) or lack of language support". General Practitioners (GPs) and other health workers are often unsure about asylum seekers' and refugees' entitlements to health (Feldman, 2006: 810; Zihindula et al., 2015). There is however always a challenge in differentiating experiences as immigrants are a heterogenous group, and as such, subgroup and individuals' own experience will vary widely (Feldman, 2006).

2.3.3 (Un) Healthy migration[1]

It has been repeatedly observed that foreign-born individuals are often healthier than native-born residents (Urquia and Gagnon, 2011; Vearey, 2012). There are some scholars who have suggested a link between HIV transmission and population

[1] This framing comes from IOM (2010) and Vearey (2016)

mobility, but this relationship is not clear-cut (Vearey, 2014). It remains complex and little understood (IOM, 2013; IOM, 2005: 22). In the early years of HIV, there was strong contention among many scholars that migration facilitated the spread of HIV between source, transit and destination communities. Today, there are limited good quality population-based studies examining HIV related risks faced by mobile populations (see Aggleton et al., 2014).

Coffee (2007) warns that to primarily consider migrants as vectors of HIV between low and high risk areas is misleading. More recent studies have shown that labour migrants are not vectors, but a population socially vulnerable to HIV infection because of family separation, limited access to health care, language barriers, and limited social support that may induce risky sexual behavior (Weine and Kashuba, 2012: 1605; Munyewende et al., 2011; Crush et al., 2010). While a large body of literature exists, "the relationship between migration and the spread of HIV to rural communities is imperfectly understood" (Crush et al., 2010: 3). It is known that migrancy may create risk factors through increased sexual risk behaviours (see Colebunders and Kenyon, 2015; Murray et al, 2011) and high HIV/AIDS prevalance in host communities, but existing knowledge about the relationship between migration and HIV/AIDS remains incomplete (McGrath et al., 2015). The understanding remains one-dimensional, suggesting that "migrants leave for the mines, engage in high-risk behaviour, contract the virus and return to infect their unprotected rural partners" (Crush et al., 2010: 3). Therefore, there remains a need to better understand these risk factors differently in the era of ART and internal, short-distant forms of mobility that are marked by frequent return visits (McGrath et al., 2015).

Equally contentious, IOM (2005) argue that HIV may also induce migration, even though there is no consensus among different scholars. One camp argues that people may migrate after diagnosis to escape stigma from their community or to access ART treatment and quality healthcare elsewhere (locally or across borders) if it is not available in their own communities (IOM, 2005: 32). This has indeed been overstated by unsubstantiated images of a "human tsunami" (Forced Migrations Studies Programme (FMSP) and Musina Legal Advice Office, 2007) and discourses of foreigners "overburdening" the public health care system. The other camp thus uses FMSP (2007) survey data to disprove these notions and arguments of HIV-induced

migration (see Vearey, 2008). Among these scholars, Vearey (2008) argues that a majority of international migrants do not enter the country to access ART. She makes this case using data that suggests that 76% of non-nationals were found to have first tested positive in South Africa while 80% were infected in the country. Further evidence also suggests that the majority of migrants move in search of livelihoods and arriving migrants are often healthier than the local population in what is known as the "healthy migrant effect" (Vearey, 2014; Sargent and Larchanche, 2011; Wingate and Alexander, 2006). In addition, more recent data shows that a majority of migrant health care users have not migrated in order to access health care, having moved for other reasons (Vearey, 2013; Vearey et al., 2016).

Nonetheless, in any case, the very likelihood of people living with HIV moving for livelihoods or asylum, or even to seek health care services makes ART treatment continuity an important migration, health and development concern given the public health threat HIV poses to sorrounding host populations. Immigrants' health is directly correlated with their degree of social integration and productivity (see Sargent and Larchanche, 2011) because mobility affects a person's ability to seek care and adhere to treatment (SADC, 2009: 5). In other words, access to ART is important to migrants' survival and secure livelihoods for those whom they employ (Vearey, 2008).

2.4 HIV/AIDS, ART and adherence

2.4.1 HIV/AIDS

HIV is a chronic condition (Friedland and Wiliams, 1999) that causes deficiency of the immune system. It is a virus that weakens the immune system, ultimately leading to AIDS (UNAIDS, 2015). A person who is HIV-positive has had antibodies against HIV detected in a blood or saliva test (UNAIDS, 2015: 25). Continuous high-level HIV replication leads to virus- and immune-mediated destruction of the key immune effector cell, the cluster of differentiation 4 (CD4) lymphocyte (Lewthwaite and Wilkins, 2009: 333) eventually causing AIDS.

AIDS was first recognised in 1981, and is the world's second leading cause of disease burden worldwide and the leading cause of death in Africa (Lewthwaite and Wilkins, 2009). The total number of people living with HIV was estimated at approximately 6,19 million in 2015 and according to the national Department of Health (DoH), half of those were on ART by the end of March 2015 (Stats SA, 2015). HIV can be treated and managed (Altice and Friedland, 1998; Friedland and Williams, 1999), but it is difficult to frame adequate responses and treatment strategies especially in Africa where, with a few exceptions, strategies to prevent the spread of HIV have been unsuccessful (Harries et al., 2001). Sometimes good quality HIV counselling and testing services are "few and far between, clinical care and the resources to treat opportunistic infections are minimal, and for most people with HIV and AIDS, there is no access to antiretroviral drugs" (Harries et al., : 410). Certainly, this state of affairs has changed as ART regimens have reached more than 15 million people worldwide by 2015 and South Africa has the largest ART programme in the world (Tanser et al., 2015: 430).

2.4.2 ART and the importance of adherence

ART is "highly active in suppressing viral replication, reducing the amount of the virus in the blood to undetectable levels and slowing the progress of HIV disease" (UNAIDS, 2015: 13). ART treatment is an important component of a strategy to support HIV/AIDS patients (Harries et al., 2001) as it stops the virus from replicating. In other words, ART treatment reduces viral load. It has improved life expectancy and prognosis in patients with HIV infection and, since its introduction, there has been an 80% decrease in mortality in industrialised nations (Lewthwaite and Wilkins, 2009: 337). There are several drug classes for HIV including protease inhibitors, nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, entry inhibitors and integrase inhibitors, and each class works at a different site (Lewthwaite and Wilkins, 2009). For example, protease inhibitors block a key viral enzyme called protease.

Only 41% of people living with HIV in the sub-Saharan region were accessing ART in 2014 (UNAIDS, 2016). Indeed, lifelong adherence is vital to good treatment

outcomes because treatment "requires life long adherence to be effective, and to prevent the development of resistant strains" (Goudge and Ngoma, 2011: 52). Sustained treatment will improve life expectancy (Tanser et al., 2015), to a point where the viral load is undetectable. Compared to interrupted treatment, continuous monitoring and treatment of HIV infection leads to better health outcomes (Krentz et al., 2011: 51).

Osterberg and Blaschke (2005: 487) define adherence as, "the extent to which patients take medications as prescribed by their health care providers". Meanwhile, Altice and Friedland (1998: 503) aver that adherence is, ""the act, action, or quality of being consistent" with administration of prescribed medicines". Adherence is characterised by patients actively participating in choosing and maintaining a medication regimen (Altice and Friedland, 1998). Non-adherence on the other hand may mean several things, but it certainly implies the opposite. It could mean not taking medication at all, taking reduced amounts, not taking doses at prescribed frequencies or intervals, or not matching medication to food requirements (Altice and Friedland, 1998: 503). A patient who does not use the medication according to strict prescription risks suffering more from the medication than from the illness it is intended to control (Anthonnisen and Meyer, 2008: 6). (Non) adherence may depend on many factors including patient characteristics, treatment regimen, clinical setting, and clinician-patient relationship (Altice and Friedland, 1998). Health infrastructure and systems to monitor adherence in the public health sector are required in order to avoid so-called antiretroviral "anarchy" (Horton, 2000; Harries et al., 2001: 410; Nguyen et al., 2007) even though non-adherence may be a choice made by a patient knowing it is problematic but the best option.

While it may appear obvious, it is curious that the literature on the relationship between mobility and (non) adherence is divided. The data are conflicted and there does not seem to be a clear consensus about it, also because there are no good studies to enable the relationship between mobility and adherence to be properly assessed. On the one hand, some argue that mobility increases the chances of non-adherence

(Osterberg and Blaschke, 2005; Kagee et al., 2010). Health care systems may create barriers to ART adherence by limiting access to health care (Osterberg and Blaschke, 2005: 491). In other words, this suggests that migrant patients who often face many challenges in accessing health care may be at more risk for non-adherence. According to Kagee et al., (2010: 88) ensuring continuity of care for people who migrate in search of work opportunities is often difficult, and such persons are considered "lost to follow-up" or "defaulters" by health authorities. But it may also be that this is how the system records them when they have actually accessed care elsewhere. Kagee et al. (2010) add that access to health care services is compounded if it involves illegal cross-border migrants ,which makes it difficult for undocumented persons to become integrated into local health care systems because they fear repatriation if they present themselves for care. Linguistic barriers when seeking care may also inhibit effective patient provider interaction and result in poor comprehension of medical instructions, leading to further alienation for many patients (United Nations High Commisioner for Refugees (UNHCR), 2014).

In a study of a migrant cohort, Tanser et al. found that migration is associated with increased risk of ART non-adherence, lost to follow-up, deterioration in CD4 count, HIV-related death, development of drug resistance and general non continuity of HIV care (Tanser et al., 2015). Several studies (Kagee et al., 2012; Camlin et al., 2010; Remien et al., 2009) investigating differentials in treatment access reported higher loss to follow-up in the continuum of care, less good adherence to care, and treatment by migrants than residents (Levira et al., 2014: 2). Krentz et al.'s (2011 :53) study in Canada reported "a significant and measurable reduction in health as proxied by both a reduced CD4 count and a proportional increase in new AIDS events" among 'returning migrants'". Their data suggest that those who move may lack knowledge on how to access care in new environments or find themselves in circumstances that prevent them from accessing services in a timely fashion. Lima et al. (2008: 1047) found an association between high rates of migration with non-adherence to antiretroviral therapy over time. Others have implicated health care workers as responsible for so-called ART "anarchy" (Nguyen et al., 2007).

On the other hand, some scholars either profess little knowledge of the association of migration and outcomes of therapy, particularly long-term adherence to therapy, or dismiss the notions that mobility leads to non-adherence. In Italy, Saracino et al. reported a fuzzy picture. The scholars could not establish with certainty "if the high rate of loss-to-follow-up was due to poor treatment adherence in the long term or, more simply, to the great geographic mobility of migrants" (Saracino et al., 2005: 754).

Levira et al.'s (2014) study in Tanzania reports less "return home to die" among rural-urban migrants after ART scale-up, suggesting high adherence among this group of migrants aged 15-59. Levira found that, "Prior to ART scale-up, critically ill AIDS patients preferred to migrate to rural for care and possibly die because of the absence of affordable treatment and care" (Levira et al., 2014: 7). Similarly in South Africa high adherence and better treatment outcomes were reported among immigrants (McCarthy et al., 2009).

Despite the lack of a consensus among these camps, it must be maintained that the patients' capacity to deal with the psycho-physical demands of the treatment is crucial for the outcome of the treatment (Anthonnisen and Meyer, 2008: 6). Therefore, whatever the case may be, it is important to recognise that migration is a psychosocial factor that may or may not place the patient at risk of poor adherence. Not all who migrate have a bad time and while migration as a determinant may mediate adherence, there is not enough data to explain how or why.

ART is a complicated regimen, and while it can significantly improve the quality of life of a patient and life expectation, the hazards of using this treatment are well-documented (Anthonissen and Meyer, 2008: 5). However, the simplistic notion that non-adherence leads to drug-resistant HIV (Bangsberg et al., 2004: 696) is contested. There is no consensus on the relationship between non-adherence (that may arise from mobility) and drug resistance. The relationship is more complicated than assumed initially (Bangsberg et al., 2004) and is continously being challenged (see Bangsberg et al., 2004). For example, the relationship between adherence and resistance has been found to differ substantially between drug classes (Bangsberg et al., 2004: 697).

2.5 Conceptual framework: Policy analysis through the lens of "the bureaucracy"

Generally, scholars and practitioners have made a strong case for undertaking policy analysis but have given much less attention to how to do policy analysis (Walt et al., 2008). There is little guidance on how to do policy analysis in low to middle income areas, especially on what research designs, theories or methods should best inform such an analysis (Walt et al., 2008). Therefore, policy analysis in general has only recently established its legitimacy as a field in South Africa, although this was not the case once for developing countries (Walt et al., 2008: 314).

In addition, nurse–patient relationships were a substantially neglected area of empirical research, especially in developing countries (Jewkes et al., 1998) but this has changed significantly. Therefore, the conceptual framework adopted by this study uses policy analysis through the lens of the health care facility as a bureaucracy embedded in a health care system. A pivotal component of an efficient system is the point of contact between the patient and the health care worker (Vawda and Variawa, 2012: 488) and a health care facility is an institution that provides that interface. In this study, it is defined as a bureaucracy, "whose units, hierarchies and roles are defined in relation to a biomedical discourse involving specific categories of actors that sets the stage for their interaction" (Andersen, 2004: 1). As Andersen underscores, an understanding of health care systems must include "health bureaucracies" (Andersen, 2004). But first, an evolution of policy analysis approaches merits discussion.

2.5.1 Top-down approaches

Hegel is credited for proposing the first theory of bureaucracy, but Weber's work holds paradigmatic status. Both scholars associated ideal bureaucracies with rationalisation, mechanism, depersonalisation, and oppressive routine (Weber, 1948). Even though there are many similarities in the way they understood bureaucracy, they differed significantly in their philosophies around themes like freedom and

democracy (Tijsterman and Overeem, 2008). Weber, unlike Hegel, saw bureaucratic office as rule-bound by "purpose rationality" and thus "inherently at odds with the exercise of existential freedom" (Tijsterman and Overeem, 2008: 81). Like Hegel, the classic Weberian model associates ideal bureaucracies with rationalisation and the latter with "mechanism, depersonalisation, and oppressive routine" (Weber, 1948).

Weber used the term "bureaucracy" to scientifically describe "the large organisations, both public and private, that manage the government programs that accompany modern economic and social life" (Birkland, 2015: 110). He saw ideal bureaucratic authority as a means of management in the hands of top executives that inescapably constitute "powerful tools for government" (Portillo and Rudes, 2014: 322).

Much of policy analysis literature and theoretical models draw on the influence of Weberian and Hegelian canons of "bureaucracy"; by perceiving policy-making as linear, with a clear division between policy formulation and execution (Walt, 1994). These analysts see policy-making in any system as avowedly political, and concerned with what government feels it ought to be doing; while implementation is seen as managerial or administrative (Walt, 1994). For health policy-making in particular:

> […] Decisions by politicians and bureaucrats within the ministry of health are communicated to planners in the health planning unit (they may or may not have been involved in policy formulation) who operationalise policies by designing appropriate programmes, with guidelines, rules and monitoring systems. These are then transferred to local health authorities (at the provincial or district level) or to health care institutions (hospitals, health centres) to be put into practice. (Walt, 1994: 153).

In other words, the top-down approach to policy analysis imagines an ideal model of "perfect implementation" in bureaucracies (Hogwood and Gunn, 1984).

In this ideal bureaucracy, Weber imagines up to six key characteristics of the ideal type bureaucracy. First, Weber argued that ideal bureaucracies are guided by the principle of fixed, official jurisdictional areas that are ordered by rules constituted in laws and regulations. In these enterprises, "authority is exercised through the impersonal application of the law" (Tijsterman and Overeem, 2008: 74). Assumedly, these rules work through:

i. Activities that are neatly governed and distributed by structured official duties;
ii. stably distributed authority to command that works through coercive means at officials' disposal; and
iii. merit-based hiring and methodical strict monitoring of duties and rights.

Second, Weber imagines ideal bureauracies that are characterised by the firm and hierarchical ordering of systems of authority and subordination marked by supervision of "lower offices by higher ones" (Weber, 1948). In these structured enterprises, Weber assumed that the governed can appeal otherwise unfair decisions to superiors in a regulated manner. Third, Weber imagines a management system depicted by office "files" that are originally preserved, as important to the character of any ideal bureaucracy. Here, personal and "bureau" money, resources and equipment are divorced from each other. In other words, Weber saw private interests as incompatible with public interests; a reason why bureaucrats should separate their social and personal interests from professional work, to instead work *sine ira et studio*[2] (Tijsterman and Overeem, 2008). In the last three ideals, Weber imagines that bureaucracies are: composed of expert trained staff, officials with full working capacity and management that follows general rules; otherwise known as standard operating procedures (Birkland, 2015: 111).

Implicitly, Weber and other subsequent top-down approaches are sceptical about the discretion exercised by implementors of policy and scholars adopting them do not often welcome bureaucratic discretion (see Davis, 1969; Polsky, 1993). Discretion is, "the perceived freedom of street-level bureaucrats in making choices concerning the sort, quantity and quality of sanctions, and rewards on offer when implementing a policy" (Tummers and Bekkers, 2014: 529). Top-down theorists see this discretion as a possibility for implementors to pursue their own private interests, working against the effectiveness of a programme (Tummers and Bekkers, 2014).

2.5.2 Replacing Weber: Bottom-up approaches

[2] This is a Latin word meaning "without hate and zealousness" or "without anger and fondness"

As shown, Weber's propositions perceive civil servants as only instrumental to policy implementation and following orders. An inherent weakness that Weber's theory of bureaus has been criticised for is that it emerges from an organic concept of the state for which the preferences of individuals are seen as subordinate to certain organic goals of the state (Niskanen, 1971). Weber assumed that in the process of policy implementation, "authority is exercised through the impersonal application of the law" (Tijsterman and Overeem, 2008: 74). He supposed that policies can be pre-planned and controlled "by the central planners responsible for developing policies" (Walker and Gilson, 2004: 1251). These assumptions reflect traditional European thinking about bureaucracy and public administration (Tijsterman and Overeem, 2008). Unlike contexts like South Africa, European thinking "ascribes a much greater importance to the state and its administrative institutions and more easily accepts that public administration embodies and serves important public values" (Tijsterman and Overeem, 2008: 73).

While Weber did not particularly delve into policy analysis or treat policy as an analytical category, his notion of bureaucracy provides assumptions of how he perceived policy (making) works. It suggests that policy entails *authoritative* statements made by legitimate public institutions about the way in which they propose to deal with policy problems (Fox and Meyer, 1995: 107) (italics mine). However, such a definition treats policy statements as "authoritative" and "autonomous" which does not always hold in practice.

The very nature of political and policy practice and implementation in South African bureaucracies questions the importance of laws and institutions as determinants of social outcomes (Landau and Amit, 2014; Vanyoro, 2015) and the autonomy of institutional practices has certainly aggravated the narrowing of transformation opportunities (Segatti, 2008; Landau and Amit, 2014). Policy implementation has been marred by coercive practices and the inability to transform public services (Segatti, 2008). Historically, inherited exclusionary "two-gate" policy aspirations of the Aliens Control Act of 1937 continue to inform suspicions and coercion of migrants in policy implementation in various public services (Segatti, 2008) and institutions are implementing their own policies that go against existing legislation (Vearey, 2008: 368; Crush and Tawodzera; 2010). It is thus salvageable that Weber's

theory of bureaucracy has been criticised for its main focus on formal elements like rules, specialisation and hierarchy at the expense of actual discretionary practice.

Walt (1994) thus clearly rejects the notion of a linear policy process, or a methodology which separates policy formulation from implementation. Implementers play an important role as policy implementors, not merely as managers of policy "percolated" downwards but as "active participants in an extremely complex process that informs policy upwards too" (Walt, 1994: 155). Understanding implementation systems and the actors responsible for implementation allows us to understand why policies do not achieve expected outcomes (Walker and Gilson, 2004: 1251).

2.5.2.1 Street level bureaucracy

In South Africa, there is a perception that many health workers are not aware of national health policies and legislation that affect their practice which leads to poor outcomes (Zihindula, 2015). However, in reality, a number of polices and guidelines are incomplete or inapplicable to non nationals, making frontline discretion in relation to the provision of services to non-nationals unavoidable. Therefore, this project is grounded in sociologic theories about the role of discretion in human service bureaucracy, particularly during conditions of uncertainty (Weiner et al., 2004: 307) and policy "grey areas in-between" (McConnel, 2010).

Street level bureaucracy creates a ground for an investigation and analysis of how informal practices "effectively become public policy", in the absence of "documents and statements developed at a central level" (Walker and Gilson, 2004: 1252). Lipsky (2010) sees street level bureaucrats as the people who meet citizens directly at the interface between citizens and government, having substantial discretion in executing their duties. These are public service workers who actually deliver the policy, and occupy a critical position in society. They provide public services that citizens regularly interact with (Lipsky, 2010) like health care. Secondly, they are public service employees of a certain sort that perfom their duties under certain conditions in which they, "define how, where and when to implement policies" (Portillo and Rudes, 2014: 324). In so doing, they have substantial discretion in exercising authority. By

determining eligibility of government benefits and sanctions and overseeing the quantity and quality of treatment received in these encounters, street level bureaucrats "hold the keys to a dimesion of citizenship" (Lipsky, 2010: 4).

However, this study modifies on a few issues in this concept. First, Lipsky's insistence on defining street level bureacracy along lines of citizenship poses conceptual and definitional challenges for those of us interested in studying non-citizen-state encounters. Migration did not take much primacy in this but this has not stopped migration scholars from investigating such interactions (Moyo, 2010; Makandwa, 2014; Vearey et al., 2016). Second, typically, bottom-up policy studies interested in health care through Lipsky's lens of street level bureaucracy have tended to restrict this category to include nurses, midwives, and doctors (see Young and Gaunt, 2014; Henderson and Pandey, 2013; Hoyle, 2013; Finlay and Sandall, 2009; Walker and Gilson, 2004). Security personnel, data capturers, clerks and receptionists are scarcely mentioned.

Not all street-level coping behaviors lead to a widening of the gap between written policy and perfomed policy, as other encounters may reflect acceptable compromises (Lipsky, 2010; also see Cioffi, 2003; Walker and Gilson, 2004; Cohen et al., 2009; Young and Gaunt, 2014; Vearey et al., 2016; for empirical examples). Street level bureaucracy scholarship has thus moved from a good or bad dichotomous approach (rule following versus rule breaking) to a focus on the nuanced ways that street level bureaucrats exercise discretion when following, bending or breaking rules (Portillo and Rudes, 2014; Skolnick and Fyfe, 1993).

2.6 Conclusion

This review revealed the gap in South African literature showing how the agency of frontline health care workers may contribute positively to the experiences of cross-border migrants accessing health care and ART in South Africa. The bulk of the literature explores how structural challenges in the public health care sector translate into denial or challenges of access to cross-border migrants. There is little in the way of considering cases of positive discretion and innovation in the frontline, particularly in a context of blurred policy and "grey areas in-between". Most policy analysis has

been top-down, focusing on macro issues like policies and how they impact on access to health care and ART for cross-border migrants. To address this, the review has made a case for the need for bottom-up studies that investigate the practices, experiences and perspectives of health care workers.

Chapter Three: Methodology and methods

3.1 Introduction

The previous chapter presented the debates in the literature concerned with migration and access to health care services for migrants. This chapter will discuss the methods used and provide justification for their suitablity. It will also present some of the challenges and dilemmas faced throughout the experience of conducting field work in two distinct research sites.

3.2 Qualitative methods

For any research design to be effective, it must consider what information will most appropriately answer specific research questions, and which strategies are most effective for obtaining it (LeCompte and Preissle with Tesch, 1993: 30). Understanding the practices, experiences and perspectives of frontline health care workers required the use of qualitative methods. This allowed me to connect theoretical paradigms to strategies of inquiry and to methods for collecting empirical material in a flexible way (Denzin and Lincoln, 2013: 29). Qualitative methods facilitated complex, textual, "thick descriptions" (Geertz, 1973; Zihindula, 2015) of health care workers' experiences and thoughts, capturing what they had to say in their own words without categorising them "willy-nilly" (Patton, 1980: 22).

Qualitative methods are privileged in their capacity to explore policy grey areas and "the complicated dynamics that underlie subjective decision-making" (Walter and Schillinger, 2004: 303). Because in human service bureaucracies, contextualized decision-making occurs primarily in direct face-to-face encounters between clients and frontline or street-level bureaucrats (Weiner et al., 2004), it was apt for interviews to be complemented with a more ethnographic observant approach (Kawulich, 2005).

Qualitative studies interested in migration and health have tended to rely on the practices, perspectives and experiences of the foreign patients (see Crush and Tawodzera, 2011; Zihindula, 2015; Hunter-Adams and Rother, 2017). However, as Patton (2002: 321) notes, the perspectives of participants "are necessarily limited,

selective, and biased". Therefore, a commitment to represent frontline health care workers in their own terms, depicting "what goes on in their lives and what life is like for them" (Lofland et al., 1971: 4) was also required. This is why this study's main object of analysis was the frontline health care worker - the street level bureaucrat - in the health care setting.

Street-level bureaucrats are defined by their association with health care provision, a public service that citizens and non-citizens regularly interact with (Lipsky, 2010). As already shown, typically, bottom-up health policy studies have tended to restrict this category to include nurses, midwives, and doctors (see Finlay and Sandall, 2009; Hoyle, 2013; Walker and Gilson, 2004; Henderson and Pandey, 2013; Young and Gaunt, 2014). This study sample also includes data capturers, administrators, clerks and receptionists; responding to Weiner et al.'s (2004) observation that few have considered the agency of these actors in a health care setting. According to Weiner et al. (2004: 307), in contrast to other street level bureaucrats, clerks are generally not trained or thought of as decision makers, but rather as individuals with a "housekeeping" role in most organisations. Therefore, less is known about the role of decision-making by clerical personnel who interface with clients (Weiner et al., 2004).

This study is exploratory in nature, seeking illumination and understanding (Hoepfl, 1997). The gap in the literature on how frontline health care workers behave in the absence of clear official state policy directives to treat cross-border migrants on ART prompted this choice.

3.3 Accessing the research sites

The study takes a multi-sited, comparative perspective between an urban and cross-border clinic in Johannesburg and Vhembe respectively. This seemed apt as Moyo's (2010) study highlights the need for studies of street level bureaucrats in migration and health that are wide scale and not limited to one institution. Building on a study conducted by LSHTM and ACMS in 2015 and long-standing ACMS engagement in Vhembe and Johannesburg, the study capitalises on existing relationships and some degree of established rapport in these sites. For example, when I arrived in Vhembe, I

introduced myself to the Facility Manager as a member of the Migration and Helath Project (maHp) at Wits University. The clinic manager displayed recognition of the past visit by the group and gave me her full cooperation. This note shows the relative ease at which I gained access to the clinic:

> *I get in and the receptionist assists me by showing me the facility manager. Her name is Dorcas*[3] *and she is polite and pleasant. After introductions, I begin my observation.*
>
> (Field notes, Vhembe, 27-10-2016).

Introducing myself in this way aggravated potential challenges of access, like mistrust, suspicion, or apathy from workers when conducting my research activities. This advantage was convenient given the limited time I had to undertake my study. When I first arrived at the study site in Johannesburg, the Facility Manager was absent, so a lady who was filling up for her assisted me. After introducing myself and the study, she escorted me into the ART patient consultation room. She introduced me to the team of six members and then I explained my study to the nurse in charge. Initially, when I mentioned referral letters as one of my interests, she seemed worried. She soon retained her calm when her superior showed her my approval letters and acknowledged that I was a colleague of another student from Wits, who is also a part of maHp.

I also had to contend with red-tape before I could begin my fieldwork, and possession of these procedural documents made access easier. I had to apply for research clearance from DoH in Limpopo and Johannesburg. Limpopo province's Human Ethics Research Committee granted me approval *(LP_2016RP35_585)* fast, which is why I began my fieldwork there. However, because of inefficiencies in the Johannesburg Metro Office, my clearance for Johannesburg (*2016-17-060*) was delayed. As a result, I had limited time to conduct fieldwork, write, analyse, and synthesise the findings from there.

[3] This is a pseudonym, and these will be used hence forth.

3.4 Recruitment of participants

For adequate representation of an urban and cross-border public health care settings, and to satisfy the comparative objectives of my study, I used a purposive sampling technique for clinics. I chose clinics that were easier to access in terms of proximity from the city, main road and amenities. Non-probability purposive sampling techniques were used to identify respondents. The criteria was that they had to be either working on the frontline as clerks and receptionists, professional nurses, counsellors, and facilitators dealing with HIV patients. For this delimitation, I had to rely on my observation to determine potential research participants. Purposive sampling allowed me to choose the sample based on who I thought would be appropriate for the study (Bless and Higson-Smith, 1995; Leedy and Ormrod, 2005: 206).

Participants were selected based on specific purposes associated with answering the research study's questions (Teddlie and Yu, 2007: 77). A purposive sampling frame is instrumental when there are a limited number of people that have expertise in the area being researched (Bless & Higson-Smith, 1995; Leedy and Ormrod, 2005). Once managers were informed of the study, they assisted in inviting staff to participate voluntarily; with emphasis made that they were under no obligation to participate in the study. Cordial relationship with the clinic manager in Vhembe helped in gaining rapport with health care workers. Sometimes, she would tell me what times were less busy, who was available, who to talk to for specific information. In one instance, she used her authority to grant me two interviews with two professional nurses. In Johannesburg, the nurse in charge of ART asked me if I would be willing to assist with some work and I offered my services. This put me in a strategic position of beneficience in which she also assisted me to connect with suitable respondents.

Because it was not possible to observe everything (Patton, 1980), I identified key programme activities related to ART treatment provision, allowing deliberate observation. I observed key "gatekeepers" and actors in access to ART treatment. I would then approach them to request and schedule an interview once I had conceded that they would be important informants to my study.

3.5 Data collection tools

3.5.1 Literature and policy review

Interpretive approaches rely on naturalistic methods: interviewing, observation and analysis of existing texts (Angen, 2000). An analysis of existing texts can complement interviewing and observation, therefore the first stage of my research was a thematic review of literature and policy documents. Key search terms included *migration, health, policy, South Africa.* While both reviews are not exhaustive, they are sufficiently comprehensive to provide a robust analysis of existing literature and policies. Policy review examined the discourse in light of context, implied policy objectives and irregularities. In so doing, it identifies cases where policies are either incomplete by not providing adequate information to resolve situations (Weiner et al., 2004), inapplicable or simply non-existent. Altogether, the policy review helped me to understand the black-box of existing policies and how they address (or don't) access to ART treatment and continuity of care for cross-border migrants.

3.5.2 In-depth, semi-structured interviews

> Don't converse with an informant for more than twenty minutes because if you aren't bored by that time he will be (Evans-Pritchard and Gillies, 1976: 240).

The first stage of my empirical research involved conducting in-depth, semi-structured interviews with frontline health care workers involved in ART treatment programmes. The interview guide was informed by the ACMS and LSHTM one, which was itself informed by previous research done by ACMS (Vearey et al., 2016). Incrementally, the research tools, all build on from each other and my study also drew on this.

Bearing in mind the above quote, interviews were kept short and concise (20-45 minutes), in order to allow the respondent to remain engaged, while providing only relevant information. Asking short questions and listening attentively allowed me to enter into the respondents' experiences and solicit their thoughts and perspectives

about what was happening (Patton, 1980: 196). Open-ended interview questions helped avoid an imposition of my preconceived categories for organising the world on participants. Direct quotes derived from all interviews were used as a source of raw data (Patton, 1980).

Interviews were scheduled at a time that was convenient and mutually agreed between me and the respondent. This did not interfere with participants' work arrangements or obligations. When I would pose potentially sensitive questions, respondents had the full liberty to pause the interview or withdraw completely, should they feel uncomfortable. Prior permission to record interviews was sought before conducting the interview.

The study began by interviewing ten frontline health care workers from a PHC facility in Vhembe District. During the course of several meetings (Cross-border and Migrant Health Forums) in Vhembe, I also "buddied" with forty professional nurses (from South Africa and Zimbabwe) whom I chatted to informally during tea breaks and lunch. In Johannesburg, I interviewed eight frontline health care workers from a PHC facility in the city. I also attended several policy meetings to "buddy" with policy-makers and health care professionals (maHp-COJ Research and Integrated Policy Unit meeting, SANAC Technical Working Group on Social and Structural Drivers of HIV, and National Consultation on Migration and Health).

3.5.3 Participant observation

Because of the sensitive nature of some of the questions, interviews could only provide "selective perceptions" (Patton, 1980: 125). Participants would not be able to provide enough data as they could be unwilling to divulge certain practices that jeorpadise their work (see Nachmias et al., 1976; Patton, 1980). As a result, many subtleties would go unnoticed (Becker and Geer, 1970). In socially desirable responding (SDR) (Zerbe and Paulhus, 1987: 250), employees may be concerned with presenting themselves "favourably under the eye of watchful researchers". SDR refers to presenting oneself favourably regarding current social norms and standards (Zerbe

and Paulhus, 1987). In a context where it is politically incorrect to be "xenophobic", respondents could easily "contaminate" the data by presenting themselves as inclusive to portray themselves in a positive light. So, to extract a richly detailed and accurate description of behaviours, situations and events (Kawulich, 2005), I complemented my interviews with participant observation. However, this assumption of SDR was later disproved by my findings which, as I will show, suggest a counterintuive relationship between participants' responses and actions.

I observed encounters between nurses and patients limited to the reception (in Vhembe) and in the ART consultation room (in Johannesburg). In Vhembe, I spent the mornings either on a bench with patients or on a chair adjacent to the reception counter to observe the different ways in which patients were received and treated. In Johannesburg I had the privilege to access the ART consultation room, in addition to the reception. There I could listen and observe interactions between nurses and patients.

I strove to understand another life world using myself as the main data collecting instrument (Patton, 2002: 14). I studied behaviour as it occurred, through exposure to routine activities of providers in the health care setting. My observation was persistent and systematic, marked by visiting the research sites repeatedly over different times of the day. Behaviours have been found to change with the season, for example (Kawulich, 2005).

I also participated in various health meetings mentioned above, spending time with health care workers and policy-makers. But, there were a few challenges with observation. Kawulich (2005) defines participant observation as a process that enables researchers to learn about the activities of the people under study in their natural setting by observing and participating in those activities. My level of "participation" in the research process was however never clear from the beginning till the end. It was difficult to ascertain my role as an observer. Patton argues that, in order to understand a world, "you must become part of that world while at the same time remaining separate, a part of and apart from" (Patton, 1980: 121). This is a complicated understanding of participant observation. How does one become part of a

world, while at the same time remaining separate, a part of and apart? Practically, this was difficult to grasp.

There was, however, a dual imperative to this dilemma. On the one hand, like Andersen (2004), I struggled to fit easily into the available roles in the clinic and this limited my participation in the core activities of my informants. After all, actors in the health care facility and their activities are defined and routinised either by their professional functions or by a pathological condition (Andersen, 2004: 3). The following quote describes my initial uneasiness on my first day:

> *I haven't quite settled in yet. To slide myself into the reception area without raising too much attention (I get uncomfortable when people stare and that can work against my observation), I behave as if I'm interested in the notice board opposite the entrance, to the left of where the queueing benches are positioned. […] After this, my interest turns to the front desk.*
>
> (Field notes, Vhembe, 27-10-2016).

The other imperative was that, on the other hand, my inquiries about basic routine, phenomena, practices and activities was justified by my position as an outsider (see Andersen, 2004), giving me access to information that some may take for granted, which is essential to understanding the social reality I was immersed in. Because of this difficulty, operationally, I prefered to use Schensul et al.'s (1999) definition of participant observation as "the process of learning *through exposure* to or involvement in the day-to-day or routine activities of participants in the researcher setting" (Schensul et al., 1999: 91, italics mine). Here, I took on the "participant as observer" stance (Patton, 1980; Kawulich, 2005), with a "peripheral membership role", to observe and interact closely enough with members to establish an insider's identity without participating in those activities (sickness or health care provision) constituting the core of group membership (Adler and Adler, 1994: 380).

The clinic is a work place and staff's hours are dedicated to tasks that entail attending to sick patients. As a researcher, one must always be sensitive to the timetables of the clinic, "both to identify useful "gaps" and make sure not to disturb more vital tasks" (Andersen, 2004: 3). I constantly had to weigh in this responsibility, as described below:

> *During my observation, I constantly reflected on my position and method. The clinic is a dynamic place, with loads happening at the same time. Between me scheduling interviews and nurses saving lives, one has to give, so one cannot afford to be selfish.*
>
> (Field notes, Vhembe, 27-10-2016).

Valero-Garces (2002: 470) argues that there are few studies dealing with the interaction between suppliers of services and immigrant users. This is because of the difficulty in obtaining permission to record or to witness such encounters and to keep the information private between suppliers and users; who may sometimes be undocumented migrants. Besides getting clearances from DoH, it was necessary to earn the trust of providers in order to access some of these interactions. While I achieved this with relative ease, it was hard to keep track of clerk-patient conversations because they vacillated between native-native and native-non-native speaking interactions. Language was therefore often a barrier. In both Vhembe and Johannesburg, as a Shona, I was not fluent in either local language:

> *At times it is hard to keep track of patient's conversations with the desk because they are interacting in Venda/Shangaan. I miss a lot because of this.*
>
> (Field notes, Vhembe, 27-10-2016).

> *Sometimes it is hard to keep track of interactions due to the dominant use of Zulu.*
>
> (Field notes, Johannesburg, 17-01-2017).

3.6 Data Analysis and interpetation

From electronically recorded interviews, I produced interview transcripts. During participant observation of clinic interactions and meetings, I kept an exhaustive descriptive written account (Patton, 1980) in the form of field notes and minutes describing my experiences and observations (Emerson et al., 1995). This method was complemented by natural conversations and checklists (Bernard, 1994). Once empirical materials had been collected, qualitative interpretations had to be constructed (Denzin and Lincoln, 2013). In order to do this systematically, I reviewed

the audiotapes, transcripts, and field notes in detail. Inductively, without trying to fit my data into a pre-existing coding frame (Braun & Clarke, 2006: 88), I analysed both the field notes and interview transcripts using thematic, open coding to identify emerging patterns, variations and categories.

Thick descriptions entailed interpreting data in the light of the context which in turn got illuminated in the light of the comments and practice. The study thus uses a naturalistic approach (Golafshani, 2003) obtained from a real-world setting through qualitative methods (Patton, 2002). Paradigm is "a systematic set of beliefs, together with their accompanying methods" (Guba and Lincoln, 1985: 15). By adopting a realist research paradigm, I was able to grasp the local constitution of social realities with special emphasis on a detailed description of how the participants understood reality and socialised (Valero-Garces, 2002: 470).

Altogether, I analysed data obtained from policy documents, interviews, minutes and field notes thematically. I started my fieldwork in Vhembe and drew several outstanding themes using open coding in my analysis. I then moved to Johannesburg where my analysis was informed by themes drawn from the Vhembe data.

3.7 Ethical considerations

All paradigms must confront, among others, axiology (ethics and values) (Denzin and Lincoln 2013). Every way of knowing contains its own moral trajectory (Palmer, 1987: 24). Denzin and Lincoln (2013: 23) argue that the politics and ethics of research must always be considered for they permeate every phase of the research process. In order to help address these concerns, I was granted ethical clearance to conduct this research by the University of the Witwatersrand Ethics Committee for Non-Medical Research on Human Subjects Protocol number H16/07/38 (Appendix G). I was also granted approvals by the Gauteng (Appendix E) and Limpopo Human Research Ethics Provincial Commitees (Appendix F) and the relevant districts in order to gain access into clinics, as shown already.

3.7.1 Informed consent

Research participants have the right to be informed about the nature and consequences of studies in which they are involved (Christians, 2013: 134). First, participants must agree to participate voluntarily without physical or phsychological coercion. Second, this agreement ought be based on full and open information. To address the first concern, the research design ensured that all interviews were conducted with participants' written informed consent and authorisation to divulge identity. Before starting an interview, participants were informed that they had no obligation to participate in the study, and they could withdraw their participation at any stage. They were given an information sheet, explaining the study in an open and honest manner. Participants were informed that there were no direct benefits and there was minimal risk when conducting this research. Once they confirmed that they understood the study, I would proceed with the interview with their signed permission. After the interview, I ensured that respondents had all the information they required, including the details of contact persons able to respond to queries arising at any point in the research.

While I had ethical clearance to conduct observation, obtaining personal consent from individuals was slightly more challenging. By and large, it was informal, depending on the amount of curiosity I raised among health care workers. Once I had introduced myself to the clinic manager to state my reasons for being there, I would also alert them that I would be carrying out observation. In Vhembe, the manager did not officially announce the reasons for my presence to staff, therefore I constantly had to greet them out of etiquette to justify my presence. In Johannesburg, only a handful concerned with the reasons for my visits were knowledgeable.

The other ethical difficulty was that, practically, I could not inform patients that I was carrying out observation. This remained a grey area that I grappled with throughout my research, because even though technically my study was interested in health care workers' practices only, in order to infer meaning from my observation, I also had to simultaneously pay attention to the responses of patients. For example, in order to determine whether the interaction at reception was between a health care worker and a non-national patient, I had to listen to the language of the patient, or observe carefully the document they produced. To my benefit, my often formal dressing was mistaken for a health care official from DoH, which made me internalise a feeling of being a

part of staff. In one incident, while carrying out observation, I was mistaken by some patients for a clerk:

> *On one occasion, two girls who are in their teens walk up to me and ignore the reception. I am sure they assume that I am the receptionist so I point them to the right receptionist.*
>
> (Field notes, Vhembe, 28-10-2016).

I also had a similar experience in Johannesburg:

> *Because I have been given a more insider status [by sitting in the consultation room], it is easier to get information. It seems quite easy for most patients to see me as a staff member because I can enter and leave the room at will while they have to sit on the queue.*
>
> (Field notes, Johannesburg, 18-01-2017).

Even though I tried to ignore these moments, the lack of consent with patients meant that I had to be smart and subtle about how I presented myself. Given that some migrant patients could have been undocumented, the last thing I wanted was to intimidate them by my appearance.

3.7.2 Anonymity and confidentiality

Besides issues of informed consent, research ethics also insist that people's identities and research locations must be safeguarded (Christians, 2013). Confidentiality and anonymity help safeguard participants against unwanted exposure. The first step towards achieving this was to blind the names of the health care facilities in writing the research report, in order to protect participants' jobs. I also used pseudonyms in order to minimise the possibility of my informants being identified in the research report.

Both approaches were not without their challenges. As Christians (2013: 136) argues, watertight confidentiality is impossible. Pseudonyms and disguised locations are often recognised by insiders in government departments or bureaucratic institutions. This is how Christians puts it:

> What appears neutral on paper is often conflictual in practice. When government agencies or educational institutions or health organisations are studies, what private parts ought not to be exposed? And who is blameworthy if aggressive media carry the research further? Encoding privacy protection is meaningless when there is no distinction between public and private that has consensus any longer (Christians, 2013: 136).

Despite this difficulty, I made every effort to minimise the possibility of participants being identified. Nonetheless, it is still possible that individuals may be identified and this was part of the consent raised in the information sheet.

3.8 Field experience

3.8.1 Positionality, reflexivity and voice

> *When I first got here, this was my first time doing research in a clinic. My first fear was objectifying disease, ill bodies and misrepresenting the patient-nurse interface. I was wearing a flowery blue summer shirt, a pair of jeans, brown formal shoes and a brown straw hat. As soon as I walked into the shade, almost everyone raised their eyebrows. Of course I knew I was an outsider, but I didn't think that it would be this obvious and striking. Now I had to gel in and earn their trust. These were genuine people with genuine health concerns. Even though I wasn't studying them, they were somehow under my scope. I was in their space. I was only a researcher with his mind on gathering findings, but not with callous disregard of their plight.*
>
> (Field notes, Vhembe, 27-10-2016).

The above excerpt describes my initial thoughts when I first walked into a clinic to do research. For me, the enterprise of constant reflection was necessary, because I had to understand my prejudices. Inadvertently, they are also part of the data. Reflexivity is the process of reflecting critically on the self as researcher, the human as instrument (Guba and Lincoln, 1985). As researchers, we are shaped by our lived experiences, and these will always come out in the knowledge we generate and in the data generated by our "subjects" (Guba and Lincoln, 1985). My observations as a research instrument rendered my perceptions part of the data (Patton, 1980), thus I was aware of my own biases, reflecting critically on them in my data analysis, interpretation and writing.

As Geertz (1988) demonstrates, the authorial voice is rarely genuinely absent. My gender, nationality, ethnicity, class and theoretical approach influenced my subsequent observations, analyses and interpretations (Kawulich, 2005). I often contemplated my positionality as a Shona researcher in Vhembe and Johannesburg, and how this had perfomative effects on me during fieldwork. These quotes best describes these reflections:

> *I'm thinking of my changing role as insider-outsider now. When I first got here, I saw myself as an outsider, asking for taxi directions in English. After my interview with Mulalo and coming to terms with the fact that Zim is just here, I start to even address taxi drivers in Shona.*
>
> (Field notes, Vhembe, 29-10-2016).

> *I have stayed in Johannesburg for the past four years, but somehow the city makes me feel like an outsider. When I'm coming to the clinic for fieldwork, I have to present myself in a way that makes me fit into the Jozi feel. The last thing I want is to look out of place and fall prey to the grime of the city because of my ineptitude to be street-wise.*
>
> (Field notes, Johannesburg, 17-01-2017).

In Vhembe, I initially felt like an outsider, but when I realised other Shonas almost owned the space and that Shona was also widely understood by locals, that perception changed. Yet, in Johannesburg, my non-fluency in Zulu positioned me as an outsider, even though I have stayed in Johannesburg for the past four years. Even the way I was treated was fascinating. As one respondent was about to introduce me for an interview:

> *She asks me, "which language do you speak?" "Do you understand Zulu?" I respond in my poor Zulu, "Not really. Ngiyabaiza [I try]". She laughs and introduces me in English anyway.*
>
> (Field notes, Johannesburg, 8-01-2017).

My nationality was also critical to how I interacted with my participants. For example, I had to grapple with some stereoptypes of Zimbabweans and not be affected or provoked by them. Here are two cases:

> *After an interview in which the participant was alleging that Zimbabweans move around a lot and form a large part of the clinic's clientelle, I mention in passing that I'm a Zimbabwean. The nurse turns pale and says, "I hope I didn't offend you by mentioning Zimbabweans".*
>
> (Field notes, Johannesburg, 8-01-2017).

> *I'm having a chat with a nurse trainee. She can't believe that I'm Zimbabwean, also because I fall out of her stereotype of "Zimbaweans as dark people". "I thought you are from Cape Town of the Eastern Cape. Most Zimbabweans don't want to learn. They just open kitchens and stay in the flats getting pregnant", she says. "Maybe it's better than doing nothing", I respond. Reluctantly she says, "Yes". "So do you have an ID? Most Zimbabweans don't have an ID", she quizes. I explain to her that I use a passport and the conversation ends.*
>
> (Field notes, Johannesburg, 9-01-2017).

I was also fascinated by the idea of power relations in the so-called "researcher-subject" relationship and how they were so easily turned. In talking to health professionals, I perceived myself as less powerful. Because of the medical knowledge they possessed, I was less authoritative and more in a "subject" position in which I could only understand this new world according to how my participants understood it. Often, in scheduling interviews, I was reminded of my dependency on my participants, without whom I had no access to knowledge to either interpret or mediate. Also, because of the nature of health care work in which sick patients are a priority, I spent numerous hours waiting for an interview. Sometimes, these were unscheduled or unconfirmed, as frontline health care workers were busy. Therefore, I saw my position, as a researcher, as largely subservient:

> *Contrary to belief, these participants exercise power over me. They dictate the tune. I have waited 4 hours in the heat for an interview, which might not even happen.*
>
> (Field notes, Vhembe, 29-10-2016).

3.9. Conclusion

In sum, while my methodology presented some challenges, it was the most ideal in answering the study's research questions. Interviews were compatible with

investigating experiences and perspectives, while observation was compatible with understanding practices. By constantly reflecting on the methodology, I was able to position myself subjectively and functionally acknowledge my biases as inherently a part of the data. By exploring relatively new and underexplored methods in migration and health studies (observing meetings for example, buddying with health care workers), the approach contributed to a whole range of possible methods for social scientists interested in bottom-up policy analysis.

Chapter Four: Results and Discussion

4.1 Introduction

The previous chapter incorporated the literature on social science research methods with my experiences during fieldwork in order to substantiate the suitability of my entire methodology. This chapter now presents the sample, its professional characteristics and the main research findings thematically. It will then pursue a discussion of the findings in the light of existing literature, in order to assess the study's contribution to current scholarship.

Table 2. summarises the professions of participants and their designated areas. In total, ten health care professionals from Vhembe and eight from Johannesburg were interviewed, including thirteen females and five males. Sixteen of them were locals while two of them mentioned that they were originally from Zimbabwe. Two of the clerks from Vhembe were affiliated with an NGO and were not formally employed by DoH, while one ART Facilitator in Johannesburg also mentioned that his work was also on behalf of an NGO.

Table 1. Themes and subthemes

Main theme	Subthemes
Providing access to health care for "problematic" cross-border patients	• Identity and documentation • Referral letters vis-à-vis "self referrals" • Language and communication: Lingua franca and translators
A migrant workforce-clientelle: bureaucratic incorporation and therapeutic citizenship?	• Perceptions of a high cross-border migrant clientelle • A migrant workforce • Bureaucratic incoporation and therapeutic citizenship?
Blurred policy spaces and "grey areas in-between"	• Analysis of existing "blurred" policies • Navigating grey areas in-between • Migrant Health Forums

There are three main themes identified in the analysis that make up the findings. These are summarised in Table 1.. The first theme addresses the imperatives of providing access to health care and ART treatment to cross-border migrants. Three subthemes emerged under this; identity and documentation, referral letters and language. Overall, this theme suggests that, in spite of difficulties associated with all three subthemes, the health care workers interviewed had developed practices to cope with dilemmas and ensure access to health care services and ART treatment for all. Nonetheless, popular negative myths and perceptions that were not backed up by evidence seemed to inform most of the respondents' "social imagination" (Larkan, 2010) of cross-border migrants. Yet, still, these negative views did not translate into the rationalisation for outright denial of care. Rather, there was an inherent contradiction in the prevalent perceptions and social imaginaries of the migrant – and the construction of the problematic migrant – co-existing with a rights perspective on health care upheld by the respondents.

Second, the study found an interesting relationship between a clientelle that was perceived by most health care workers as "migrants" or "from outside" with a "migrant workforce" and how this translated into a politics of inclusion, deference, bureaucratic incoporation and to a certain extent, therapeutic citizenship. While most respondents expressed the view that cross-border migrants affected services for locals, again with little evidence to support this, their understanding of migrancy, and in Vhembe, their proximity to the border appeared to impact positively on how they rationed services to cross-border migrants vis-à-vis locals.

Last, using policy analysis and empirical evidence, the study found a gap in policies, systems and guidelines to address continuity of ART treatment for cross-border migrants. While there is a perception that many South African health workers are not aware of national health policies and legislation that affect their practice which leads to poor outcomes (Zihindula et al., 2015), a number of polices and guidelines were incomplete or inapplicable to cross-border migrants. This made frontline discretion unavoidable. Therefore, health care workers had to use their discretion, sometimes rule-bending, in order to facilitate access to health care for migrants. The section concludes that frontline discretion plays a key role in facilitating access to care and ART for cross-border migrants.

Table 1. Overview of participants

	Vhembe		**Johannesburg**		**Total**
	male	female	male	female	
Nurses	2	5	1	4	12
Administrators/Clerks	1	1	0	1	3
VCT Counsellors/ ART Facilitators	0	0	1	1	1
Facility/Clinic managers	0	1	0	0	1
Total Respondents	3	7	2	6	18

4.2 Providing access to health care services and ART treatment for "problematic" cross-border migrants

4.2.1 "We don't arrest persons for becoming sick"[4]: Identity and documentation

> *When they come we don't send them back. We don't send them out. We open the file for each and every patient, regardless. We don't even need the passport or ID number. We open the file, for as long as you know your date of birth. We just open the file and then give you the file number. So we'll continue using that file number. When you come you just produce the file number then they give you the file. Regardless that you came here legally or not, we just offer the care* [health care services in general].
>
> (Sharon, Nurse, Vhembe, 29-10-2016).

There was an inherent contradiction in the prevalent perceptions and social imaginaries (Larkan et al., 2010) of the migrant – and the construction of the problematic migrant (see Moyo, 2010) – co-existing with a rights perspective on health care upheld by the respondents.

Despite the complications of a lack of identity documents (IDs) for some cross-border migrants who health care workers described as often in precarious and illegal positions, according to my respondents, the issue was not a cause for them to deny access to health care services. Consistent with existing studies (Pophiwa, 2010; Makandwa, 2014; Vearey et al., 2016; Hunter-Adams and Rother, 2017), and contrary to others (HRW, 2009; Crush and Tawodzera, 2011), there was no evidence to support the hypothesis that legal status is a deterrent factor among migrants who seek treatment at primary health care clinics. The opening quotation represents the position of a majority of health care workers that I interviewed in Vhembe and Johannesburg.

Health care workers professed that documentation made their work more effective. If well coordinated, it assisted them in many ways including; knowing who their patient is in order to also avoid the "duplication of services" (to meet headcount) and minimising "lost to follow-up". Other contact details such as the patient's address and phone number were also pertinent, but their importance was undermined by challenges of presumed borrowing of IDs and fake addresses among cross-border

[4] Yvette (Nurse, Vhembe Cross-border Health Forum meeting, 25-10-2016).

migrant patients. Yet, in reality, my analysis suggests that these perceptions are misplaced, and are borne out of a frustration with a health care system that has not adequately engaged with migration.

While the health care workers I spoke to acknowledged the importance of documentation for patient registration, they stated that they still offered the care even without it. In other words, the concern that health care workers had with the dilemmas they faced in identifying undocumented cross-border migrants, and how these impacted negatively on adherence, ART stocking and treatment outcomes, did not translate into rationalising the denial of ART treatment. One respondent argued:

> *We don't require much identification, obviously we are not Home Affairs so whether you've got papers or you don't have papers, when you're here to seek for health care we give you that health care.*
>
> (John, Nurse, Vhembe, 17-01-2017)

But unlike John, some health care workers alleged that DoH deemed it compulsory for them to "identify" their patients before providing health care services. Despite this knowledge, they described some innovations that they had instituted *themselves* in order not to compromise access to health care for undocumented migrants. The health care workers I interviewed argued that they had innovated other ways, like using a patient's date of birth and name instead of an identity number. Onias, an ART Facilitator stated:

> *On our department we don't ask for ID or whatever. We don't do such. To register patients, some if they do have do you know what happens? […] We tell them, "do you know what? We need to fill up like a file you understand". They give us. Some they say they don't have we fill up the date of birth, that's what we can use. We can make it up with a date of birth.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

Likewise, this is what the Facility Manager of a clinic in Vhembe had to say:

> *It's compulsory, but they will say that I don't have a passport. And you can't just say, "I'm not going to attend to this person because he doesn't have a passport". Because we use the date of birth and even the names, and then*

that's why its difficult for us to attend to them because today they come with this name, with another date of birth.

(Dorcas, Facility manager, Vhembe, 3-11-2016).

As I later found out from the Administrator working in the same department as Onias, his use of the term "on our department" implied that other departments, namely the antenatal care unit (ANC), turned away patients who did not have valid passports. As Mary later confirmed:

By law we are not allowed to ask clients for identity documents. Yeah, but you'll find in some cases they ask, "give us your passport, heh, has it expired?" Especially at our antenatal clinic the sister who's doing it these days, she won't follow that. I don't know who started it, or it's politicians. It's only in our clinic. If you don't have a valid passport they don't take you, but when I say to them go to X or Y clinic, it's only done in this clinic for pregnant women. I don't know, it was the arrangement with the boss or what, I don't know. On my side I don't pick. HIV side clients I don't ask them for ID. Even if I work with volunteers I teach them, they do whatever I do.

(Mary, Administrator, Johannesburg, 22-01-2017).

Clearly, departmental and individual discretion played a key role in access to health care services for undocumented migrants, with those at ART receiving it, unlike the ANC ones (Lipsky, 2010). An informal chat with a colleague undertaking his research at the same clinic revealed that the ANC there had a reputation for manning the queue with Home Affairs officials who would even arrest undocumented or "illegal" migrants attempting to access services there. Meanwhile, Dorcas' response reflects a will by the health care worker to compromise, but it also suggests suspicion and low levels of trust between the health care workers and cross-border patients.

There was a perception among some health care wokers that some cross-border patients "abused the system" by using different names and dates of birth to "collect" lots of treatment. While there was nothing to stop locals from being involved in this presumed system, such incidences or suspicions were never mentioned; backing up negative perceptions and suspicions of the foreign "other". Some health care workers accussed cross-border patients of masquerading by using the identity documents of other locals. In Johannesburg, one nurse described such an encounter:

> *I've had people that I question their identity. Somebody comes here and tells me who they are. It's a lady the other day who came with an ID. She claimed that she was the person on the ID, a local ID. She was not that person, and I managed to find that she's not that person just by talking to her. It was so easy that just after asking her a few questions over and over she ended up saying to me, "it's not mine". She couldn't even get the date of birth right. So I had conversation with her over and over.*
>
> (John, Nurse, Johannesburg, 17-01-2017).

Health care workers concerned with the "unreliability" and "untrustworthiness" of Zimbabwean migrants were more prominent in Vhembe. One opined:

> *It's just that they are not reliable sometimes. That's the problem on so many things. Because you don't know this person if it's Tapiwa or Simbisai*[5]*. This one who is sitting here, is having this letter, maybe a book or a transfer letter, and you make a mistake you don't take that transfer letter. Tomorrow somebody will come back with that and say I'm Tapiwa, I'm Rumbidzai. The identity problem it's an issue to us, because we are unable to identify them.*
>
> (Janet, HIV Coordinator, Vhembe, 27-10-2016).

The main challenge in treating undocumented migrants, as described by the frontline staff I interviewed, was that they allegedly visited the clinic with different identities. When such incidences occurred, health care workers stressed, cross-border patients could easily change facilities or skip medication and appointments, knowing that they would not be accountable to medical recourse because of their unknown identity. Or as one health care worker believed, some migrants took many drugs for illicit purposes (this will be discussed further in the following pages) as one person could have two files and use both to collect treatment either at the same facility, or in different facilities. One nurse opined:

> *We can find that one person has got two files here or three. The first day when he come, he will call another name and surname, because there is nothing that he can be seen that this person is the same. The next week when he come we will open another file, with another name and surname.*
>
> (Nonsi, Nurse, Vhembe, 3-11-2016).

[5] Tapiwa, Simbisai and Rumbidzai are typical Shona names.

In order to qualify her allegation, the health care worker in question further narrated her experiences with a particular patient whom she believed tried to do this:

> *It happened here, another man […] he came, calling another name. But somebody knows him that, "no this is not your name, I know you. You are who, who". That man you see, he is collecting being one but he is collecting by two files. But if there was something that could identify them, it would be better.*
>
> (Nonsi, Nurse, Vhembe, 3-11-2016).

Other health care workers held similar beliefs. In Vhembe's farming areas or small villages, there were no daily clinics and so mobile clinics visited some of these areas, serving an estimated population of more than 16 000 (the figure may be even higher). The clinic visited 120 farms at more than 20 visit points, and so, migrant farm workers on ART treatment relied on it for these services. The nature of the mobile clinic entailed that health care workers traveled long distances, and according to one health care worker, the furthest distance was about 100 kilometers from Musina, which meant that going to work was also a trip. According to Nancy, operating in different areas often resulted in the "duplication of services", as some patients who were undocumented cross-border migrants could collect treatment in different areas:

> *The challenge is we still have those ones that are not yet trustworthy enough to say. We have to open the file ka this area, ka this farm, and open the file ka the other area and she arrives there, "I'm new". Meanwhile it's the patient that's been on ARV for a long time.*
>
> (Nancy, Nurse, Vhembe, 31-10-2016).

Likewise, in Johannesburg, the issue of perceived dishonesty and unreliability of cross border patients on several requirements was also raised, although there was no consensus among interviewees. As one frontline worker opined:

> *The challenge is about honesty, you know some people they are not honest. Especially the migration neh, according to me the way I see it, they are not honest. A patient can come from other clinic neh, and come to our clinic and do you know what the patient say? They say, "you know what, I was taking my medication from this clinic and that clinic refused to give me a transfer letter". While they are lying they know that they come for visit, they don't tell us that they come for visit. […]. Now it's a challenge to us because we don't have history for that patient.*

(Onias, ART Facilitator, Johannesburg, 18-01-2017).

However, interestingly, one male nurse highlighted that cross-border mothers were more dependable than locals when it came to taking care of their child's "Road to Health Card" for immunisation. In his view:

> *Interesting enough, the people that have problems with regard to the road to health card are the locals. I don't know, for some reason people from outside of South Africa they take very good care of that card. They will have it. They will have it for 12, 15 years. There's children that were born in the early 2000s that the mother still have the cards. The local ones are the ones with the biggest problem. They deliver yesterday tomorrow the card is not there anymore.*

(John, Nurse, Johannesburg, 17-01-2017).

As aforementioned, this contrast between reliable-unreliable patients seemed to be more of a matter of perception and in fact, it begs the question whether the concern about migrant users being deceptive was misplaced, and should rather be more about the health care system not engaging adequately with migration. Indeed, it illustrates that in South Africa, many unfounded assumptions associated with the scapegoating of foreign nationals persist (Vearey et al., forthcoming). Vearey et al. (forthcoming) found that, in South Africa, current health responses fail to adequately address the movement of people, and call for the urgent development of migration-aware health systems: a whole-system response whereby population movement is embedded as a central concern in the design of health interventions and policy.

4.2.1.1 Dealing with "problematic" patients

By way of considering the significance of the belief among many health care workers that undocumented cross-border patients were unreliable and untrustworthy –overall problematic-, an explanation was needed. This begged the question: from the health care workers' perspective, what could be the reasons for cross-border migrants to resort to such "unethical" practices? Health care workers submitted different explanations and problematic patient categories. In Vhembe, one believed that, for cross-border migrants, these practices were a strategy to collect treatment for their

HIV positive counterparts in need of ART treatment. In her view, for reasons known only to cross-border migrants themselves, "these" people may not have access to ART treament back in Zimbabwe or in Vhembe. She explained:

> *[…] they will come and collect lot of treatment. And the person can come and say, "I lost my treatment, I lost this one", while they know that there is somebody else at home who's having the same condition as they are having. And they have to take that treatment. And they can come and can say today tomorrow and that other day with different names […]. And you can't force that person that you are Dorcas while its not Dorcas.*
>
> (Dorcas, Facility Manager, Vhembe, 3-11-2016).

This respondent believed that, besides "faking" identities, sometimes cross-border migrants even lied that they lost treatment.

Indeed, one would assumme that such suspicions that many health care workers harboured towards cross-border migrants would result in them denying them treatment. Counterintuitively, they did not overtly express resentment towards cross-border migrants for employing these tactics. Rather, health care workers understood that health care was a right for everyone, and held several rationales to justify their innovations. It is curious that locals were never mentioned as doing this, a positioning which has been observed in other studies (Moyo, 2010; Makandwa, 2014), suggesting that health care providers complained without hard evidence that such practices were happening. Indeed, this rhetoric seems to be scapegoating (see Vearey et al., forthcoming) as seen in how the blame for such practices was essentially associated with non-nationals and not local patients. Therefore, the suspicion and othering of cross-border migrants by health care workers was largely perceptive.

Individual health care workers drew conclusions from their own subjective experiences which did not hold for others. For example, when I asked one VCT Counsellor whether she knew of alleged cross-border patients who came to "collect" medication, sometimes for illicit purposes like drugs, her response was a simple "No".

4.2.1.2 Rationales for providing care to undocumented and other "problematic" cross-border migrants

Health care workers invoked various rationales for the discretion they practiced on the issue of documentation. Although not referencing policy per se, some health care workers invoked "humanistic", moral and ethical reasons, preferring to use the language of non-discrimination. This illustrates Weiner et al.'s (2004) finding on health care worker – uninsured patient interactions in the United States. Consider the following responses by frontline workers in Vhembe:

> *We don't let a patient die because they have no ID. We are here to save lives*.
>
> (Vese, Nurse, Vhembe, 29-10-2016).

> *What I know is that me as a clerk I've been taught to not discriminate, you know. If you don't have a passport, a asylum, or what, it means like you can't be treated? That's not how we work here, if you have a document or you don't have, you get treated.*
>
> (Mulalo, Nurse, Vhembe, 28-10-2016).

Likewise, in Johannesburg, one nurse stated a similar view as a matter of a shared humanity:

> *Here we don't turn them away. They are fellow humans. We treat them like everyone else.*
>
> (Bheki, Nurse, Johannesburg, 28-01-2017).

Some individuals gave examples of how they advocated for patients:

> *[…] and sometimes you find them gossipping of me, "eish this one she is always advocating for clients". Maybe it's because I understand more about HIV. I'm also an AIDS activist and I understand. And more policies I know. They were implemented in my presence.*
>
> (Mary, Johannesburg, Administrator, 22-01-2017).

Public health advocacy of the right to health of the above nature is often missing in discourses from health care providers. Another health care worker explicated her rationale in terms of an idealised concept of government service which she strongly believed in. As if reminding me of the government's mission, she opined:

> *Remember the mission of the government or the objective is to assist anybody irrespective of the country, of the race, of the nationality. So we are still sticking on that. We don't deny anyone a service because he does not have an ID.*
>
> (Nonsi, Nurse, Vhembe, 31-10-2016).

Similarly, in Johannesburg, John invoked the South African constitution as his entrée:

> *Akiri the constitution says health care is free for all who are in this, who are across the borders of South Africa, irrespective of the nationality or that they came here illegally or not. It doesn't specify. It says if they are in the borders of South Africa they've got a right to health care.*
>
> (John, Nurse, Johannesburg, 17-01-2017)

John and Nonsi had internalised their role as state-agents and bureaucrats. As Lipsky's (2010) concept of street level bureaucracy suggests, frontline workers often shape citizens' understanding of their relationship with the state (Portillo and Rudes, 2014). In this example this relationship is positive, but in some case the attitudes of workers may negatively influence cross-border migrant users' relationship with the state.

For others, the sense of duty to serve everyone regardless of their nationality drew from their hippocratic oath to uphold specific ethical standards. During an observation of the Vhembe Cross-border Health Forum meeting, I was struck by how one health care worker understood her role as a nurse:

> *It's not our responsibility as health workers to discriminate whether you come from this country, whether you've done this. Our pledge as nurses says, "you don't discriminate according to religion, whatever" […] we are supposed to accommodate.*
>
> (Yvette, Nurse, Vhembe Cross-border Health Forum meeting, 25-10-2016).

These findings destabilised the discourse on "medical xenophobia" (Zihindula et al., 2015; Crush and Tawodzera, 2011; Misago, et al., 2010; Human Rights Watch (HRW), 2009; Landau, 2007; Pursell, 2005; Nkosi, 2004) and confirmed that undocumented migrants may face challenges but this is not evidence to show they are outrightly denied health care. One lady from the Zimbabwean Department of Health

who believed that South African public health care workers denied undocumented cross-border migrants access to health care posed the following question:

> *Is it easy as health facilities for migrants to gain access? For example, if someone has TB or HIV and they do not have proper documents, can they just come and say, "I'm so and such a person with a condition", or that's when the immigration is called in? Because that can be the other issue why people are not forthcoming.*
>
> (Mercy, Zimbabwean Nurse, Vhembe Cross-border Health Forum meeting, 25-10-2016).

In response, a South African health care worker said:

> *The ones that are coming, we are able to document them, get the same file with others, start the same treatment. They are in the system. So the ones that may be fearing maybe to come to the facility, it becomes a challenge. […] But in our facilities, we don't arrest persons for becoming sick. […] So under health, there's no way they should be intimidated. They should be free to come, you may give them that information. They should be free to come.*
>
> (Yvette, Nurse, Vhembe Cross-border Health Forum meeting, 25-10-2016).

However, even though Yvette dismissed Mercy's claims, they are indicative of suspicion that many undocumented cross-border migrants have of the public health care system based on either popular narratives, or their own past experiences which affects their treatment-seeking behaviour (Zihindula et al., 2015). Yet, the frontline health care workers I interviewed alleged that these claims were not neccessarilly the overall picture. The notion that undocumented migrants were denied access to health care in Vhembe was outrightly dismissed by this respondent as a myth:

> *[…] we are working with them [cross-border migrants] very well. […] You find here at the cross border meeting talking about, "the illegal migrants are afraid to come to the institution", all those things. But me, I can't see them doing that. They just walk in and they know they don't have documents. We are not dealing with documents here. As long as you give us your name and date of birth, we identify you like that and we help you. We are not Home Affairs, we let those to do their work and the police to do their work but if you are at the hospital, I think you are at the safest place to be helped.*
>
> (Janet, Nurse, Vhembe, 27-10-2016).

Likewise, in Johannesburg, the health care workers I interviewed challenged the narrative that they denied undocumented migrants access to health care. One ART Facilitator who claimed to be originally from Zimbabwe defended his local Nurse colleagues:

> *[…] most people hear that nurses abuse foreigners. But according to people that I've worked with neh, like to say I've not seen any abusiveness, no I haven't seen one. According to the people that I've worked with, me I've never experienced abuse to foreigners. Maybe in other facilities they are there but according to people that I've worked with, I've never experienced such.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

This position resonated with the view of this VCT Counsellor:

> ***KV**: Does anyone get turned away if they don't have a letter, IDs?*
> ***Nonhlahla**: No. We are trying to help them. Even if they don't have IDs and whatever, we are helping them. Yes, we are trying.*
>
> (Nonhlahla, Johannesburg, VCT Counsellor, 22-01-2017).

But one frontline health care worker who mentioned that she was originally from Bulawayo, Zimbabwe, and started working for COJ from 1997 highlighted that, a lot had changed in terms of how non-nationals accessed care ever since she arrived at the clinic in 2008. Yet, in her view, there were still some nurses who continued to ill-treat foreigners in other clinics. She opined:

> *[…] before I came to this clinic 2008 it was very hard for a foreigner to access health care in the clinic. But, when I came it improved. Now anyone can come from anywhere especially to my department they will access treatment. As long as they are having proper documents, which is a transfer letter of where they come from. Whether it's from Nigeria, whether it's from Malawi, Zimbabwe, majority is from Zimbabwe. Whether he's from Soweto. Some they come from Orange Farm. Yah, if you ask them why are you not going to access treatment near to your place, they always say, here you always treat us […] with dignity.*
>
> (Mary, Administrator, Johannesburg, 22-01-2017).

She also added that:

When they [South African nurses] are alone they complain, they will always complain, "we are working for these people they are wasting our tax money". Those things. We got trained on customer care but some people do the wrong things despite getting that training because of personal attitudes. That attitude I don't know when it will finish.

(Mary, Administrator, Johannesburg, 22-01-2017).

Because interview data may sometimes be "contaminated", I sought to validate the responses of my participants which conflicted. Through interviews, respondents could easily tell me what I wanted to hear in order to expediently shield themselves from external critique that could expose discrimination in their practices (what I have referred to in my methodology section as SDR). Street-level bureaucrats often believe firmly that they treat all clients alike (Lipsky, 2010: 112) and, after all, interviews may only provide "selective perceptions" (Patton, 1980: 125). Therefore, during my observation, I also paid particular attention to the issues of IDs and how health care workers interacted with undocumented migrants. I also observed other pettier issues such as contact details (addresses and phone numbers).

Most cross-border patients in Vhembe demonstrated experience with accessing the health care clinic in which I did my observation. The casual manner in which they approached the issue of documents was interesting:

Another foreign patient presents herself. She is asked by the clerk
***Clerk**: Une pasipoti [Do you have a passport]*
***Patient**: Nhasi handina kumbouya nayo ini [Today I did not bring it with me]*
The clerk registers her nonetheless.

(Field notes, Vhembe, 27-10-2016).

At this point. I have been here for 6 hours and no one has been turned away for documentation, address, phone numbers or ill-treated or abused.

(Field notes, Vhembe, 27-10-2016).

Contact details were also required by health care workers who believed that they were pertinent in locating patients for follow up. Besides documentation, some patients lacked several contact details required for registration like addresses and telephone numbers. I observed an interaction between a cross-border patient (who did not have

an identity document and a phone number) and a clerk. The interaction deserves to be presented at length:

> *I now listen in to an interaction at the desk between a Venda speaking clerk and a Shona speaking elderly female patient (she looks 55 or so)*
> ***Clerk**: Haana passpoto, asylum, refugee? [Do you have a passport, asylum permit, or refugee document?]*
> *Patient does not respond*
> ***Clerk**: (because patient is a bit far at this point) Hamuzvinzwi? Huya kuno [Can you not hear or understand me? Come here]*
> ***Patient**: Shona ndoyandinonzwa [I can only speak and understannd Shona]*
> *One person behind who is female (she look like she is in her 20s) also speaks Shona, so she interjects by asking how much medication costs*
> ***Clerk**: It's free, asi moda kutenga [do you want to buy?] (she chuckles jokingly)*
> *This clerk is ad libbing language. They generate conversation with the elderly patient which goes on.*
> ***Clerk**: Uchanyatsotaura Venda [You will be able to speak Venda].*
> *This client does not have documents but the clerk continues to register her without any ID.*
> ***Clerk**: Une mukomana, une murume? [Do you have a boyfriend, do you have a husband?].*
> *I take it that the patient has responded yes. The clerk continues.*
> ***Clerk**: Anonzi ani? [What is his name?]*
> ***Patient**: Learnmore Chihuta*
> ***Clerk**: Manumber emurume wako? [Where are his phone numbers?]*
> ***Patient**: Handimazivi [I do not know them]*
> ***Clerk**: Haumazivi, ah ah (tone of shock) [You do not know them? Rhetorically].*
> *The clerk ignores the situation and continues filing in the records. The patient asks.*
> ***Patient**: Ndoenda kupi? [Where should I proceed to?]*
> ***Clerk**: Enda uko [Go that way]*
> *The elderly patient is granted access and proceeds to the chronic section.*
>
> (Field notes, Vhembe, 27-10-2016).

However, despite these practices, some health care workers acknowledged that negative attitudes held by some health care workers still played a critical role in the quality of care provided, confirming Mary's earlier position. One stated that :

> *Some people may have attitudes but they must know that they [migrants] have a right to be treated free there, at the clinic.*
>
> (Yvette, Nurse, Vhembe Cross-border Health Forum meeting, 25-10-2016).

In Johannesburg, Mary reiterated her initial position a second time:

> *They [City of Johannesburg] tell us you don't discriminate against our brothers and sisters who come from out of South Africa they are also our brothers they've got rights to health care. But you know, human beings are human beings.*
>
> (Mary, Administrator, Johannesburg, 22-01-2017).

However, yet again, there was no definitive evidence to suggest that such attitudes were prejudiced, xenophobic, or exclusively directed towards cross-border migrants on the basis of their nationality, or documentation status. One Clerk described her relationship with one of the nurses who frequently assisted in registering patients. She hinted that sometimes this nurse portrayed negative attitudes towards patients. Describing an encounter I had also observed where three school girls approached the nurse in question to register, she opined:

> ***Thelma**: […] the other one, you saw her. The nurse. She is harsh. But I can call that person and assist them. […] You see I was talking to the school girls that time? She said I must leave them to go outside. When she go out I went and called those kids to asssist them.*
> ***KV**: Why would the nurse decide to turn someone away, is it documents, ID, nationality?*
> ***Thelma**: No, we can help everyone. She have or he doesn't have document, ID, whatever. On name and date of birth we can assist. But we are three of us and our attitude is not the same. But because I know how to facilitate or to talk to the person, if someone sent her out, I learn to call her or him. I know it will be different to us with the colleague, but it's the chance for the patient to get help. It's the attitude, its not part of her work. Its just an attitude. […] We are different.*
>
> (Talent, Clerk, Vhembe, 31-10-2016).

Talent argued that none of the attitudes suffered by the three patients at the hands of the "harsh" nurse were contingent on documentation or nationality. If anything, she believed that they were simply based on personality.

Indeed, the data presented so far presents analytical complexity. What explanation can be used to understand the conflicting narratives by health care workers and patients of so-called "medical xenophobia" (especially found in Johannesburg) and those in Vhembe that largely suggest inclusion, deferrence and some form of bureaucratic incorporation (Walter and Schillinger, 2004; Marrow, 2012; Gell-Redman et al.,

2014)? The responses of the health care workers I interviewed largely suggest that they were going out of their way to facilitate access to health care for undocumented cross-border migrants. Using the available literature, there are a few possible explanations. For one, Lipsky (2010) suggests that it would be much of a mistake to infer that ethnic, racial or nationality appeals always prevail in affecting discretionary judgements as that they never prevail. He found that white bureaucrats may be more lenient or tolerant with black clients out of fear of being accussed of racial biases. Lipsky (2010) found San Francisco teachers who over-reacted to the potential for biased behavior by awarding black children good grades when in fact they were not learning at an acceptable rate.

Vhembe in particular has it's own specific particularities and sets of geo-political and historical dynamics which deserve a more detailed investigation. Another possible explanation lies in methodology; "methodological nationalism". Studies of migration and access to social services have been criticised for falling into "methodological nationalism" (a term which has already been delat with) in terms of how migrants are defined and conceptualised (Wimmer and Schiller, 2003; Madhavan and Landau, 2011; Myroniuk and Vearey, 2014). Some studies (Vearey et al., 2016) have started to grapple with this bias. But migrant exceptionalism – focusing exclusively on an individual non-national sample - has led scholars interested in access to health care services for migrants in South Africa to indiscriminately focus on the narratives of the migrants, with little attempt to understand the perspectives of local health care workers (and citizens) for a balanced and measured empirical critique. While newer studies have grappled with the fact that neither group can be studied without the other (Vearey et al., 2016), most who have studied access to health care for migrants have generalised their findings without adequately considering the heterogenity of South African service providers' perspectives, experiences and practices.

Last, in what Willen (2012) calls the embodiment of migrant illegality in both the epidemiological and phenomenological sense, this intersection may cause unauthorised migrants to avoid care-seeking for fear of arrest or deportation (Quesada et al., 2011) or internalise exclusionary arguments that they are undeserving of health care (Larchanché, 2012). Therefore, as found by Zihindula et al. (2015), it may be true to a certain extent that undocumented non-nationals adapt their treatment-seeking

behaviours because they are afraid to access health care services in most South African health care institutions (psychosocial effect). The above-described perceptions could indeed potentially stigmatise health-seeking experiences of non-nationals. For example, an ART Facilitator at the Johannesburg clinic who is originally from Zimbabwe explained that:

> *To be honest neh, you see we've got patients, especially people from outside South Africa. When they come to clinic, you know, they are scared like, "you know what, we are in a foreign country these people are going to do this to us". But you know, when they discover they know that, "you know, no you are also a migrant" in that but you are working in a facility neh, some of them they'll start becoming open. They start to tell you something that you didn't know. Sometimes they tell you, "you know what, I was scared to speak to that nurse but since I know we are from one nation, I can be able to open up". It happens.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

This finding is consistent with Lipsky's (2010) argument that clients sometimes judge services positively if they are treated with respect regardless of the quality of services. In the light of past experiences of bureaucratic neglect (Lipsky, 2010: 96), patients may assume that the "agency is unlikely to be responsive". But, it is misleading to use these psychosocial internalisations of discrimination (Zihindula et al., 2015) to infer a generalised assumption of "medical xenophobia" indiscriminately, to apply to all health care contexts.

4.2.2 Referral letters vis-a-vis "self referrals"

> *We don't have a policy to do that, you need to use your own discretion.*
>
> (Nonsi, Nurse, National Consultation on Migration and Health, Johannesburg, 22-11-2016).

Health care workers in Vhembe and Johannesburg also cited the lack of referral letters by most cross-border patients as a significant setback and dilemma to their work. Referral letters emerged as one of the barriers to achieving adherence and continuity of care. The health care workers I interviewed stated that they could not provide ART treatment if patients did not have them. One respondent in Johannesburg opined:

> *Referral letters are a problem. If someone doesn't have a referral letter it's a very very big problem. There it's a problem, they won't get help. They won't get help.*
>
> (Mary, Administrator, Johannesburg, 22-01-2017).

The lack of harmonised referral systems across cross-border facilities in the SADC region resulted in what some of the health care workers referred to as "self referrals". "Self referral" is a practice employed by patients when they refer themselves to a clinic of their choice without a referral letter from their initiating facility.

However, notwithstanding Mary's view, several frontline workers stressed that they did not deny patients access to their services because of a lack of referral letters. Again, there were stark dissensions in responses. One respondent opined:

> ***KV**: And what about foreign migrants without referral letters?*
> ***Nonhlahla**: We accommodate them. We do whatever we can. We start, we look what they have and then we do whatever we can just to carry on. We cannot turn them, we never turn away anybody here.*
>
> (Nonhlahla, VCT Counsellor, Johannesburg, 22-01-2017).

Yet, in explaining how they dealt with patients without referral letters, two Clerks in Vhembe stated that they such registered patients, but they were not sure what sort of treatment these types of clients received once they reached the Nurse. The two Clerks stated:

> *In terms of registration, no problem of that. I can give the person the file. The problem will be at the cubicle.*
>
> (Talent, Clerk, Vhembe, 31-10-2016).

> *[…] that referral letter is what is needed actually. They'll show me uri I came with this referral letter from where where where where. Eh no problem, I open a file for him. I direct him straight to the nurse, at the chronic side there. And once they get in they get treated. Those who don't have I still refer him or her to the nurse and I don't know what nurse is saying to him.*
>
> (Mulalo, Clerk, Vhembe, 27-10-2016).

Like Walter and Schillinger's (2004) study of indingent patients, I found that the good intentions of the clerk who bends the rules to permit a clinic visit did not assure that

the unreferred patient would receive coherent health care; confirming split power relations among this hierarchy of medical and administrative staff. The importance of referral letters, especially for nurses was indeed unsurpassed. Nurses opined that referral letters provided them with vital information they needed to continue treatment to patients that moved from one facility to another. This nurse in Johannesburg stated:

> *[…] They [cross-border migrants] come in as they are, they don't have any paper. So you don't know any history. What medication they were taking, what are their blood results? How long they've been on that treatment. Which treatment are they taking because sometimes they don't even know which treatment they are taking.*
>
> (Beauty, Nurse, Johannesburg, 10-02-2017).

Therefore, one nurse in Vhembe claimed that it became difficult for them when:

> *[…] some people from outside, […] come here and tell us, "eh I want to collect my treatment" when she or he is not having a document to show us what kind of treatment she or he taking. They always come and say, "I'm here for my ART treatment" without any document. […] We can't continue with the treatment to the person when she came or he came and say, "I'm here for my treatment" without any document, anything to show us I am taking this treatment. By document I will see the prescribed medication, the referral forms and whatsoever and the type of medication then I'll give.*
>
> (Moyo, Nurse, Vhembe, 29-10-2016).

For one Nurse in charge of the ART programme in Johannesburg, referral letters served an administrative imperative of accounting for drugs to DoH. She stressed:

> *It gets complicated when they don't have this letter. You know we have to account for drugs to the Department of Health and ART is an expensive drug. I need it. And remember, some people are using it for nyaope*[6]*. It gets complicated.*
>
> (Princess, Nurse, Johannesburg, 08-02-2017).

[6] Nyaope is a uniquely South African street drug that is highly addictive and destructive. It is a fine white powder that is usually combined with marijuana (dagga) and smoked.

Similar to the concern raised by Princess, there were also other nurses who claimed that, when in doubt, the referral letter served as confirmation that the patient had been diagnosed of HIV in the first place. The suspicion harboured by health care workers towards undocumented cross-border patients resurfaced. Like Princess, one nurse in Vhembe believed that some patients lied that they were HIV positive to access ART treatment for clandestine and illicit purposes. According to her, such illicitness included lacing medication with other recreational drugs to make *nyaope*. She stated:

> *Sometimes you know that some people use the ARVs as drugs you see. So that thing of just giving them by saying that, without evidence, by saying that I'm on treatment. They know this treatment most of the people they know it. […] We don't just give like passing that, I have got my treatment. No.*
>
> (Sharon, Nurse, Vhembe, 29-10-2016).

So far, studies have identified the robbing of HIV patients' drugs as the chief way that they get sold for *nyaope* (Chinouya et al., 2014). In a Durban study, Grelotti et al. (2014) found that ARVs were being diverted because some individuals used them recreationally. Media reports in 2008 described how some South African HIV patients and school children smoked ARVs for their "hallucinogenic and relaxing effect" and in 2010, issued numerous reports on *whoonga* – a cocktail of drugs believed to contain ARVs (Grelotti et al., 2014). The only other reports of recreational ARV use they mention are from the United States where HIV patients were found to abuse and/or divert drugs, and informants described how protease inhibitors, most notably ritonavir, enhanced or prolonged the effects of ecstasy and methamphetamine and were being sold with illicit drugs as "cocktails" (Grelotti et al., 2014; Larkan et al., 2010).

In order to assert the the predominance of this belief of "diversion" among other health care workers, I asked one individual in Johannesburg concerning this matter in the brief interaction below:

> ***KV**: Do you believe you get any unreliable patients who come to get the medication for drugs?*
> ***Nonhlahla**: No.*
>
> (Nonhlahla, VCT Counsellor, Johannesburg, 22-01-2017).

This lack of consensus suggests the existence of some sort of convenient mythology among health care providers who associated precarious health seeking with illicit motives. This "social imagination", as Larkan et al. (2010) put it and illustrate, should be understood as embedded within the same context that structures the epidemic in the first place – a history of inequalities, and individuals and communities forced to deal with scarcity as a result of their history of being at the sharp end of structural violence. Without detailed ethnographic work amongst the assumed drug-using migrant populations to establish the existence and extent of recreational (ARV) drug use and little hard data verifying the existence of a recreational market for ARVs (Larkan et al., 2010), these claims should be dismissed as unreliable and constructions of "social imagination".

However, for Lipsky (2010: 140), such stereotypical assumptions are functional because, while street level bureaucrats are expected to exercise discretion to respond to individuals and individual cases, in practice "they must process people in terms of routines, stereotypes, and other mechanisms that facilitate work tasks". The content of coping mechanisms may well be reflective of the prevailing biases of cross-border migrants in South African society and the need for bias rooted in the work structure, but stereotyping may be thought of as a form of simplification (Lipsky, 2010: 142). In this case the only danger is that, the emergence of recreational use of ARVs in the "social imagination" of health care providers can legitimise actions that are aligned with delaying access to treatment (Larkan et al., 2010) to undocumented migrants, who though clinically eligible may be deemed socially undesirable.

Other health care workers in Vhembe identified truck drivers as one mobile group that often came to "ask" for ART treatment without any referrals. They described truck drivers as people who "just walked" into the clinic without any referral letters or medication. This was the classic case of what they called "self referral". While patient best-practice recommended that people taking medicine for a long-term condition like HIV, not having a medical record, must take empty containers from their last medicine, one nurse described truck drivers as:

> *[…] just moving. They can just come in and say "I'm asking for treatment, I don't have enough I have to go and stay in Zimbabwe" or "I have to go back, I'm going to Cape Town and I don't even have treatment anymore", without*

any referal, any medication. They just say "I know it", and it's difficult for us to issue the treatment to those kind of people because they want to know where did we take the treatment to. […] When they pass by they will just stand here and say "I'm asking for the medication, I'm getting what what what what for ARVs but I don't have any document to show you that I'm taking the treatment".

(Dorcas, Facility Manager, Vhembe, 3-11-2016).

Vhembe lies just across the border and many truck drivers going to or from Beitbridge may find clinics in the district closer. Thus, it is conceivable that a truck driver can run out of ART medication while in-transit, or routinely came to access ART treatment across different health care facilities in the region, using Vhembe clinics as one option. But the existence of truck stop clinics can be used to quiry the veracity of this claim.

Health care workers in Vhembe and Johannesburg expressed their willingness to provide treatment to patients without referral letters on the condition that the patient professed knowledge of the medication they took or showed a medicine container. As one nurse in Vhembe stated:

We can't deny you treatment if you come in here and said "I'm on this treatment, I take it on this time", "I've lost my pill" or "I've forgoten my pill" or "they have finished". We can assist you. But if you don't have any knowledge, it's a problem.

(Janet, Nurse, Vhembe, 27-10-2016).

Responses in Johannesburg also resonated. Proof in the form of containers was mentioned as one other way for patients to profess their knowledge of the medication they were on. One responded:

Those who don't have referrals they come this side. Some of them they are taking ARVs from Zimbabwe. Example, let me say from Zimbabwe neh, some of them they come with the containers. They are telling me that, "Nonhlahla, I'm taking this medication from my country now I don't have referrals and I'm left with only two". So I ask Sister Bheki, "sister Bheki can you give them 10 tablets maybe". And then I booked them ukhuthi come and start afresh here. And then they will draw the blood. While they are waiting for that blood, they will still have medication. […] You know what, you can't say because you are taking ARVs and you are coming from outside South Africa and you don't have medication right now at least you have to wait until disparate of time. We

can't do that because he's already, or she is already on ART. And there's a proof because they came with a container.

(Nonhlahla, VCT Counsellor, Johannesburg, 22-01-2017).

While frontline health care workers like Nonhlahla expressed their willingness to "go the extra mile", interestingly, in Vhembe, this desire seemed to be compounded by the fact that many health care workers there believed that patients lacked the general knowledge that ART was a complex regimen. One clerk submitted:

[…] most of the patients they don't have knowledge on the ART treatment. They don't have that knowledge. They think maybe you just pour water and drink 5 times a day. They don't follow the procedure itself.

(Mulalo, Clerk, Johannesburg, 27-10-2016).

Could it be possible that the lack of knowledge influenced how cross-border migrants approached the issue of referral letters? For example, in identifying barriers to ART access, Nguyen et al. (2007: 137-138) found that "not being told anything" were patients' most common complaints, and staff cited lack of time for not explaining things to patients, adding that "patients would not understand anyway". With this in mind, I found a different picture when I interrogated other possible factors why "self-referral" could be a norm among cross-border migrants. I asked the question, "are health care workers doing enough to make patients understand why they need to move with referral letters?" Two nurses responsible for prescribing, initiating and continuing ART treatment for HIV patients in Vhembe mentioned that they trained their patients never to move for a long period without a referral letter. Another nurse in Johannesburg claimed that they always told their patients to move with their "green card", which she described as their "passport". Their views resonated with each other:

[…] when we start giving them treatment we tell them, "if ever you go somewhere maybe, you go and work somewhere, please come and report to us so that we can give you a transfer letter to the place that you are going". And some we do refer them home. Like in Zim we do refer them home with our referral system here; we refer them home. Some we receive them, they refer them from home to us. So we teach them that when you go somewhere, when you see that you can't come back maybe for some time, maybe for two to three months then just come, we'll give you a referal letter. You'll get treatment where you are going.

(Alois, Nurse, Vhembe, 3-11-2016).

> *If they started with ARV there in Zimbabwe, we request the transfer letter, yah. And if she decided, if she started this side, and decided to go back to Zimbabwe, we advise her that she must also take the transfer letter from here to Zimbabwe so that she can continue with her treatment.*

(Sharon, Nurse, Vhembe, 29-10-2016).

> *The green card, it's their passport to go everywhere. When we initiate them we say, "when you go and visit anywhere, have that card with you because it has the whole information you need if you run out of the treatment".*

(Beauty, Nurse, Johannesburg, 10-02-2017).

Owing to a lack of harmonised referral systems (which will be discussed later) this intervention seemed to be limited only to the facilities in question and I found no evidence that nurses on the other sides of the borders were doing the same, which explains why MSF have piloted referrals and called for their standardisation (MSF, 2012). Also, those who were most likely to move were also more unlikely to hear the local languages, which meant that they faced difficulties understanding these instructions during the training. Moreover, there was a perception by one nurse I interviewed, responsible for monitoring HIV patients in Johannesburg, that high patient mobility undermined such efforts. She quizzed:

> *If it's a visitor who's coming here for a short while maybe for a week, where do you find time to speak to him about adherence? Adherence we, even with our clients here, some they have a challenge adhering to their medication that we give them.*

(Bheki, Nurse, Johannesburg, 28-01-2017).

Such a perception of mobile patients (especially cross-border migrants) is likely to undermine any will on the part of the provider to teach the importance of adherence or referral letters. Interestingly, as if to deflect blame, most health care workers in Vhembe and Johannesburg unanimously believed that livelihoods were a major reason why mobile patients (internal and cross-border alike) did not travel with referral letters or defaulted. They cited a few examples of such instances.

[…] some will be telling you that their bosses don't want them to come or to go to the clinic or to go to the hospital. […] And you find that the person is not coming for some time, and then the person will tell you that my boss did not want me to come.

(Alois, Nurse, Vhembe, 3-11-2016).

The same problem happens with internal migrants. And also the farm workers. Like today I was having the other guy. He works for the other company there, other farm. The problem is that the owner has a lot of farms, then he just come tonight and said, "we are going to Polokwane, we are going to start in Polokwane". Then there is no time to start your transfer letter, there's no time to do anything, there's a job, which means it leads to defaulting. People are just moving. Tonight your brother will phone you, "come come there's work in Jo'burg". You board your taxi and you go. But that's how thing are, we can't change them, you can't say the person will just wait for tomorrow for transfer letter, for what what.

(Janet, Nurse, Vhembe, 27-10-2016).

Another challenge is transfers. The transfer in from other, it doesn't matter from another clinic or or from another province. You find that some of the tests that we normally here have not been done there. […] We can't blame them [nurses] there because you find that when someone wants to be transferred to another place, to another clinic, let's say they are coming from Limpopo they want to come here. They just come as a, like for their normal visit and they say, "ehm I want to be transferred to Jo'burg" for instance and then they don't give them enough time to take the bloods or they don't have the patience to wait, have the bloods taken and have the right picture. Maybe they rushing for something like a job.

(Bheki, Nurse, Johannesburg, 28-01-2017).

According to Lipsky (2010: 153), attributing the cause of clients' situations to the individuals themselves without considering other mediating factors like social and environmental contexts locates responsibility "in a place that absolves the helper from blame". "If the client is to blame, street level bureaucrats are shielded from having to confront their own failures or the failures of the agencies for which they work" (Lipsky, 2010: 153). This tendency of positioning the user as the problem, and not the health care system itself, resonates across my data.

Meanwhile, a Zimbabwean Nurse implicated the deportation regime and livelihoods seeking as culpable in the apparently high defaulting rates and lack of referrals among cross-border migrants from Zimbabwe:

If they have treated or diagnosed and treated this person and he is following treatment here [South Africa] and for some reason he is arrested because he doesn't have the proper travel documents, and then he comes to Zimbabwe when he is due for deportation. If there was going to be continuum of care, […] we give them what we can or refer them to the hospital. But then you find that these guys, their number one concern is not treatment. They will want means of livelihood. So they would ask them "Are you coming from Chiredzi?" so that he refers them there so they go to the hospital to get proper letters for referral. They'll tell you kuti [that] "ah vakomana vandimirira [my boys are waiting for me], I have to go back." Because if they are not there by such a time, because at times they are talking to their bosses, "I'm coming back, we are being deported, so can I come next week?" So their key driver is means of livelihood, so if they have to balance getting drugs and getting a job, the drugs must give.

(Ngubane, Nurse, Vhembe Cross-border Health Forum meeting, 22-10-2017).

Ngubane was frustrated that cross-border migrants ignored that HIV treatment can ensure that livelihood strategies continue as found by others (Vearey, 2008).

There were mixed beliefs on whether patients who came without referral letters should access ART or not. One Clerk in Vhembe believed that truck drivers must be entitled to ART treatment even if they did not have referral letters. He opined:

We have truck drivers which are passing each and every day. Those people they can't go clinic by clinic or hospital by hospital asking for referral letter, you understand. Those people they travel thousand miles, thousand kilometers, but we know as health care workers that a truck driver can't go with a referal letter all over where he is going. […] He's a ART patient but we understand, everywhere he go, he can ask for ARVs and he'll be given those ARVs, even hospital. [..] Truck driver come here, he gets treated here, with the referal or without the referal letter.

(Mulalo, Clerk, Vhembe, 27-10-2016).

Another Clerk at the same clinic was convinced that nurses provided ART treatment to patients that were not registered (on file and as part of the headcount) to receive medication at the clinic:

[…] *It's difficult on that position because someone can give that person the medication maybe for a week or two so that she can go back. That person can go back to take transfer or to collect but the others can't give if the person doesn't have the transfer letter. So it's difficult because when the person come*

> *to ask, it's to ask for the sake of the health. But others can't give. Those who don't have transfer letters have challenges. It depends on the person who's going to help. Others can give for 2 weeks, they are not allowed to give her for the full term, maybe for months, maybe they can give for 10 days, 5 days. But others can't give even for one day. It depends on the attitude of the person.*
>
> (Talent, Clerk, Vhembe, 31-10-2016).

However, It was not clear whether truck drivers and other cross-border migrants received treatment without referral letters in Vhembe. While Mulalo argued that truck drivers were receiving treatment at the clinic, he sometimes contradicted himself by also claiming that he was only responsible for registering patients, which made him unaware of what actually happened in the cubicle when the patient without a referral letter was being treated. This was implied in one of his other responses:

> *Mostly I can hear the nurse, cause mina I don't have that much power, I'm not a nurse I'm just a clerk, but I can hear a nurse say "I can refer you to a hospital because here we don't have enough drugs for you".*
>
> (Mulalo, Clerk, Vhembe, 27-10-2016).

This quotation was followed by another qualification:

> *[…] even truck drivers, you can see it's a border town, truck drivers can't go taking transfer here, go to Polokwane, transfer, from Zim, from Zambia with a transfer, its difficult for him. So those ones can be treated.*
>
> (Mulalo, Clerk, Vhembe, 27-10-2016).

Is it possible that Mulalo was confused on whether patients without referral letters actually got the treatment or were referred to the hospital for reinitiation? Chances are these contradictory responses suggest some sort of bureaucratic dilemma which made it difficult for Mulalo to safely ascertain whether a patient had actually received treatment or not. Because there are no specific guidelines on what to do in these cases, he had no knowledge of what the best practice in cases such as these is. This was reflected in the interview with other nurses whose expression of ignorance to what happened during registration suggested deep-seated divisions of power between medical and administrative staff. Under these conditions, it is likely that nurse do not share medical knowledge and practice with administrative staff.

Nurses at the clinic also appeared uncertain about when to provide patients with a few tablets, or refer them to the hospital for reinitiation (in the case of Vhembe) or reinitiate them themselves (in the case of Johannesburg). All in all, it was in their discretion to determine what "best practice" to invoke. Given this dilemma, it is not surprising that there were also different views on the issue of referral letters among health care workers in the Vhembe clinic. Different nurses dealt with the issue of referral letters differently on a case by case basis. Some nurses believed that a referral letter was "not that a big deal" and referring patients without referral letters to doctors for reinitiation at the nearest hospital was the best approach:

> *So the problem is with those who come just saying that, "I started the treatment in Zimbabwe" without a transfer letter. But its not that a big deal, we refer them to the hospital to start with a doctor and the doctor willl end up transfering them back to us. But they must be seen with the doctor first.*
>
> (Sharon, Nurse, Vhembe, 29-10-2016).

This can be interptreted in a negative light also. "Referral is a way of dealing with clients in need without really dealing with them"; what has been called symbolic service (Lipsky, 2010: 132). Consistent with Lipsy (2010: 132), it is arguable that referrals are used as one of the least costly ways to process clients without providing services thus, the clinic "may maintain benign images of helpfulness and service, without explicitly having to turn clients away". For example, there were many instances in which nurses provided pills for a limited duration to assist patients until they produced the required referral or returned back to the facility that initiated them. Others believed that referring the patient to the hospital was the best action to take especially for patients who came from farther places, and that "their hands were tied" (Marrow, 2012), but only made an exception in instances where the patient was from "nearby" facilities. In these instances, these nurses stated that they could go the extra mile by contacting the patient's initiating facility in order to verify whether they had the file:

> *Most of the time we refer them there [hospital], for them to takeover because there is a doctor who is stationed there dealing with the ARVs. Then most of them we ask them, can they please go there. Because you can't just say you have to go without the treatment, that's not fair. Then we have to do something about that. But for the nearbys, we can even contact the place where they are coming from and talk to them. When they say its true that this*

person is taking the treatment until this time […] it's then that we can issue the treatment because we are sure that this person is taking the treatment.

(Dorcas, Facility Manager, Vhembe, 3-11-2016).

Dilemmas of these sort have led to contestations about the power possessed by street level bureaucrats in their autonomy. On the one hand, Portillo and Rudes (2014) argue that state power is "turned on its head" by the practices of street level bureaucrats and it is articulated differently forming a delineation of the relationship between citizens and the state. Meanwhile Hudson (1989) is of a different view. Hudson conceives the "boundary" spaces of citizen-state interaction more as sites of "dilemma" rather than the exercise of power. These dilemmas may be more particularly salient for the provider if the clients are immigrants, poor or have a different ethnic or racial background than the public service providers (Lipsky, 2010). The fact that Mulalo conceded his powerlessness in the statement, "I don't have that much power", or is simply not aware that he possesses it, challenges Portillo and Rudes' argument.

This is why for Hudson (1989) bureaucrat autonomy is nothing more than street level bureaucrats' expression of responding strategically to structural circumstances of powerlessness like limited resources, understaffing, burnout from long working hours and in this case, not knowing what to do. There are strong reasons to believe that, sometimes, this is why non-nationals may become easy targets for personal frustrations. "It's not as simple as being xenophobic - the facilities are overburdened and understaffed" (Bateman, 2010). This is a strategy they use to protect their own work environment (Hudson, 1989). All too often, street level bureaucrats are accused of being biased toward particular social groups like locals, but such perspectives fail to take account of the influence of street level bureaucrats' work on their attitude (Lipsky, 2010: 141). In this case, while health care workers retain significant power, it can be argued that they remain constrained by a lack of knowledge, policy and guidelines, and as a consequence, they are enveloped in interactions that are not of their own choosing (Portillo and Rudes, 2014). If any, their power lies in their inability to "do the job according to ideal conceptions of the practice because of the limitations of the work structure" (Lipsky, 2010: xvii) and in shaping citizens' understanding of their relationship with the state (Portillo and Rudes, 2014).

All the above data suggests that bureaucratic discretion (Birkland, 2015) plays a significant role in the decision to grant ART medication; with the caveat that respondents were themselves lower in hierarchy with the health care system studied (not doctors or senior managers). Discretion, in this case, is the ability of the health care providers to make decisions about how they will administer policies and programs with relatively little input or interference from other institutions (Birkland, 2015: 119). This confirms Birkland's (2015: 119) assertion that the amount of discretion exercised by an agency is a function of its resources (expertise, cohesion, legislative authority, policy salience, and leadership) and the tolerances of other actors in the political system. Birkland (2015) argues that each actor has a "zone of acceptance". Such agency decisions have to encounter "political" dilemmas and questions and bureaucratic discretion (much like legislation), "is part of the process of deciding who gets what from government" (Birkland, 2015: 118). After all: "Health is so political actually. It's not just about a patient coming here and getting a service" (Modisenyane, National Consultation on Migration and Health, Johannesburg, 22-10-2016)**.**

4.2.3 Communication strategies: Lingua franca and informal translators

4.2.3.1 Lingua franca

Communication forms a key part of any nurse-patient interaction, particularly when dealing with HIV (Kaplan et al., 1989; Cameron and Williams, 1997; Anthonissen and Meyer, 2008; Peräkylä, 2010; Kourkouta and Papathanasiou, 2014; Hunter-Adams and Rother, 2017). Although my participants acknowledged the need for programmes to address challenges of high workload, understaffing and drug shortages to enhance quality access to health care services, I also found that South African health care institutions have not been sufficiently transformed to reflect the different groups that make up the country; particularly cross-border migrants. South Africa is a multilingual society with eleven official languages (Hunter-Adams and Rother, 2017). Vhembe and Johannesburg are both multilingual contexts meaning that the health care sector there, like elsewhere in South Africa, is characterised by linguistic and cultural diversity. While communication in health care is a complex issue in itself, the situation is often further complicated by language and cultural barriers (Putsch, 1985).

Again, according to my respondents, these challenges are compounded by the presence of non-national patients who speak other languages.

As I observed interactions between native speaking health care workers and non-native speaking patients, I was struck by the effort some health care workers put into connecting with patients different from themselves, often in extremely demanding circumstances (e.g., heavy workload). A Clerk who regularly interacted with diverse patients at the reception expressed his willingness and motivation to deal with language barriers of any sort. I asked him how often he came across language challenges, and he responded:

> *Everyday, everyday. Everyday I can see a person who don't know English language, our language. Zim language which is simple, talking Congolese, yah, it's most difficult to treat him. But somewhere where I can't understand, I can't just say, "let it go, just go and find somewhere else". I give him a blank paper, I refer him to the nurse. That's how I do it.*
>
> (Mulalo, Clerk, Vhembe, 28-10-2016).

Overall, despite the daunting complications of language, frontline health care workers in Vhembe and Johannesburg argued that they managed to perfom their duties competently. There was a will to ensure that mutual understanding was achieved in the face of limited linguistic resources. In Vhembe, the majority of the health care workers reported their first language to be either Venda, Shangaan, Tsonga or Sotho. However, some health care workers had learned sufficient "medical Shona" to care for patients without having to rely on translators; a lingua franca of sorts. While languages like Venda and Shona are different, some of the words are the same. Recognising this striking resemblance, some respondents suggested the existence of a common medium of communication that straddled as a hybrid of both languages, or what one respondent referred to as "touch ups". These were some of the responses:

> *For now I know some some other words from Zim I communicate well, even though I speak Venda.*
>
> (Moyo, Nurse, Vhembe, 29-10-2016).
>
> *On my side I can say all the language I tried. Even that side, […] [laughs], I'm just trying so that the person get helped, I'm trying. I can't speak Shona*

very well, but if the person doesn't talk English or Venda, I'm trying to speak Shona. I know she can't hear properly but she will understand what I want to say. I try to make it work, even if it's difficult but I'm trying.

(Talent, Clerk, Vhembe, 31-10-2016).

***Mulalo**: I speak Tsonga.*
***KV**: So how do you interact with patients?*
***Mulalo**: Its not much difficult because I can speak Venda, I can speak Sotho, I can speak all languages from here Musina. Even our neighbour country Shona I can tell touch ups. Its not different. They link, Venda and Shona. Yah, it's not much difficult.*

(Mulalo, Clerk, Vhembe, 28-10-2016).

Similarly, in Johannesburg, all the frontline health care workers I spoke to professed to be proficient in Zulu, but invoked the linguistic similarity between Zulu and Ndebele as their lingua franca with most patients from Zimbabwe. Unlike Hunter-Adams and Rother's (2017) study in Cape Town, which found language to be a vehicle of discrimination, and the refusal to speak English by Xhosa speaking frontline health care workers, in instances where patients could not speak Zulu or any other native language, they highlighted that they also used English as a lingua franca. They opined:

Most people know English, it's very few those who don't understand English, very few. Very few.

(Beauty, Nurse, Johannesburg, 10-02-2017).

The other problem that we facing here eh obviously is the language. Yah but with Zimbabweans it's not so bad because the Ndebele language is very close to the Zulu language so we do understand each other most of the time. It's here and there where you find somebody from Zimbabwe who cannot fully understand some Zulu or some English.

(John, Nurse, Johannesburg, 17-01-2017).

The issue of language is a problem but usually we deal with some migrants from SADC countries and if they can speak English you can communicate with clients in English. We can communicate in English.

(Mary, Johannesburg, Administrator, 22-01-2017).

Hunter-Adams and Rother (2017: 2) argue that in addition to being denied access and being placed in longer queues, language barriers and the lack of medical interpretation are further examples where migrants experience "medical xenophobia". But, from their argument, it is difficult to ascertain whether they refer to "medical xenophobia" as institutionlaised in the apparent lack of translation services in many public PHC clinics, or as practised by health care workers themselves. Unlike Zihindula et al.'s (2015) study, respondents argued that failure in communication did not lead to denying or delaying of services. Rather, what I found was that language versatility was a key innovation that facilitated access to health care services and ART treatment for non-native speaking cross-border migrants. In Vhembe, I observed several occasions where native-language speaking nurses switched to Shona when they realised that the client was not fluent in any local language. Likewise, in Johannesburg, the nurse in charge of the ART room quickly adapted English when she realised that her patient could not understand Zulu. This is contrary to many reports from health care users, who often claim that speaking English works against them. The excerpts below demonstrate the proficiency of health care workers in both clinics:

> *One foreign patient does not have a phone number. The male receptionist is speaking in Venda but at this point he seems to have adapted to Shona. He addresses her in Shona, with a tone of concern, "Kana muchodzoka next time mudzoke nenumber handiti?" [When you come back next time please bring your phone number, okay?]. She nods in approval. He allows her to proceed for her vital signs.*
>
> (Field notes, Vhembe, 27-10-2016).

> *Nurse asks, "amapilitsi anjani?" [How is the medication?]. The patient does not respond and she repeats herself. This time, the patient responds, "You said what?" The nurse catches on and reiterates, "How are the tablets, any side effects?" "No, they are fine" says the patient.*
>
> (Field notes, Johannesburg, 17-01-2017).

The above responses demonstrate some complication, but suggest no resentment against non-nationals speaking in either English or merely unable to speak any native language. Some nurses I spoke to in Vhembe believed that they had developed some sort of schema in order to comprehend common patient symptom reporting. Schema theory propounds that, "Presumably once a schema on, say, making a plane

reservation or reporting symptoms of an illness, is activated, a host of other related concepts and information will be ready for the reader/ listener to tap into. This will help less proficient learners, in particular, to comprehend challenging texts" (Cameron and Williams, 1997: 417). While this theory alone cannot adequately explain the linguistic innovations among health care workers in Vhembe, it can help analyse the responses below:

> *[…] to some who are not fluent in English, especially from Zimbabwe, when you speak with that person, I mean, we will understand each other because most of us can hear, can get one or two languages in Shona. Especially the basic ones, the head, you know, the stomach, whatever. So when you talk to them at least we do understand each other.*
>
> (Alois, Nurse, Vhembe, 3-11-2016).

> *So I used to call someone to intepret for me. But now that little bit of saying, "I have pain headache what what, labour pains", that one I can understand.*
>
> (Sharon, Nurse, Vhembe, 29-10-2016).

Alois seemed to have mastered key descriptions and reporting of basic symptoms of illness like the head and the stomach. According to Clerks in Vhembe, they resorted to lingua franca when patients failed to respond to the inquiries of the clerk as required during registration. Their agency was not prejudiced on the identity document that a patient presented to the health care worker (i.e. a passport being equated to foreigness and the inablity to speak native). Rather, the health care workers I interviewed believed in two scenarios: 1. That some cross-border migrants had local IDs while not being able to speak any native language; or 2. That those who presented passports during registration sometimes tended to be fluent in native languages like Venda.

Therefore, there was no clear-cut way to differentiate who the migrant or local was, with certainty. While some health care workers were able to navigate their way through communication barriers arising from language differences using "touch ups" (Mulalo, Clerk, Vhembe, 28-10-2016) or "patch ups" (Onias, ART Facilitator, Johannesburg, 18-01-2017), my respondents suggested that there was still need to meet the needs of some monolingual health care workers. The facilities I visited in Vhembe and Johannesburg had not dealt with language and cultural problems in a

formal operational sense (Putsch, 1985). In other words, there were no positions for official on-site interpreters and no in-service training programmes for interpreting techniques. Therefore, while bilingual employees were not formally trained or paid for interpretation, they frequently served as informal interpreters (see Putsch, 1985: 3345 for a similar case). One nurse described her experiences in providing care to cross-border migrants who often spoke a different language to hers:

> *It's a problem, the language barrier, […] because there are some from Congo. We can't speak French. There are some from Malawi. We can't speak Chichewa. Some from Zimbabwe. […] but the nurses who are originally from here in Musina, they can speak their languages because maybe most of them they are originally from there. I don't know. But maybe it's because they've been staying with them for a long time. Those nurses who are staying here originally who are here from Musina, they can communicate well with them but when it comes to other communication problems those yah. Like myself, when I came last year, it was a problem because I can only speak Zulu, Tswana, Venda. At least I can speak Tsonga, but when it comes to Shona and Chichewa it was a problem.*
>
> (Sharon, Nurse, Vhembe, 29-10-2016).

Likewise, in Johannesburg, my participants reported difficulty in interacting with patients who spoke foreign languages without any knowedge of English. There appeared to be a hierarchy of linguistic difficulty. According to them, problematic languages included Chichewa (Malawi), Portuguese (Mozambique) and French (DRC). Here are some of the responses:

> *It's a big big challenge especially those who are coming from Malawi. Eish, really it's a challenge. Because they don't know English, they don't know at least Zulu nyana. You know the majority it's from Malawi. You know they say mina I speak Chichewa.*
>
> (Nonhlahla, VCT Counsellor, Johannesburg, 22-01-2017).

> *Language is quite challenging. You know what, the challenging one neh is from Malawi. And Mozambique, Zimbabwe, Mozambique most of them they know Zulu. They work with people, they learn. So it's not challenging. But people from Malawi neh, it's quite challenging because you find that they speak Chichewa, and we don't have anybody who can speak Chichewa here.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

> *There's the likes of the Mozambicans they speak Portuguese only which is extremely difficult. I don't understand Portuguese at all. The DRC they come speak French.*
>
> (John, Nurse, Johannesburg, 17-01-2017).

Another health care worker cited sign language as a barrier in communication between deaf patients and untrained nurses:

> *You know this client is a sign language. She came in the morning. And look at the nurse's attitude sometimes. She was initiated in August, she came. She was supposed to come on the 4th of January. Now that she didn't come on the 4th they are toasting her from pillar to post. She is now from retesting, instead of the sister giving her the treatment. Maybe she didn't even understand the contents of counselling because our counsellors, even myself, we are not trained for deafs.*
>
> (Mary, Administrator, Johannesburg, 22-01-2017).

Considering the above responses, it is problematic to asssume that "all is well" just because some multilingual health care workers, some who owe the benefit of being born in Vhembe for their language proficiency, and some who simply "go the extra mile" can cope by themselves. While some monolingual nurses ended up knowing how to treat non-native speaking patients with time:

> *When we just come here and work here, it's just Greek words really. After two to three days you know that when she says like this or she talk like this, she means this.*
>
> (Dorcas, Facility Manager, Vhembe, 3-11-2016)

Given the sensitivity of HIV, it is still arguable that this grey area compromised on the quality of care and had negative consequences on treatment outcomes because cooperation between provider and patient is imperative for the achievement of good health outcomes (Zihindula et al., 2015). Communication is an essential precursor for many aspects of health care quality, including considering medical advice and taking medicine correctly (Zihindula et al., 2015; Hunter-Adams and Rother, 2017). More especially when complicated drugs like ART are concerned; any bit of information missed could have detrimental affects on viral load suppression. Those who cannot communicate with health care providers are less likely to adhere to treatment, to seek

care or follow-up appointments, or receive preventive services (Hunter-Adams and Rother, 2017). Surprisingly, communication across language and cultural barriers in low- and middle-income areas has received low priority than in the U.S., relative to other "pressing issues" in the health system (Hunter-Adams and Rother, 2017: 1-2).

4.2.3.2 Translators

> *There was once a translation service but you know like it was an NGO. I don't know what happened. Maybe they didn't get the contract to continue. We once had a translation, and I was part of it the translation organisation but now it's no longer there.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

South Africa currently has no official system for medical interpretation (Vearey, 2012) - the facilitation of communication between a medical provider and patient who do not speak the same language (Hunter-Adams and Rother, 2017: 6) – and, as illustrated by Onias, the public health care system has over the years relied on short-term NGO funds for these services. Therefore, the clinics I visited in Vhembe and Johannesburg had not dealt with language barriers in the formal operational sense by having translation services. Rather, health care workers had to innovate ways to address the challenge. The use of informal translators was a widespread practice and the informal translator role was very fluid and a matter of situational convenience. In other words, who got to be an translator was not limited to health care workers, but, in some situations, the nurses used their own discretion and called upon the services of other non-medical employees, patients, family members or anyone available and fluent in the language in question. Again, for conditions like HIV, as found in Hunter-Adams and Rother's (2017) study, health care workers acknowledged that resorting to these practices had negative consequences on issues of confidentiality.

While scholarship has found that international migrants struggle to communicate with healthcare providers (Vearey, 2012; Zihindula et al., 2015; Hunter-Adams and Rother, 2017), there is little in the way of literature that acknowledges the practices adopted by health care providers to try and facilitate access for cross-border migrants amidst language barriers. During my fieldwork in Vhembe, I once played the role of

an informal translator. One nurse was treating a Shona speaking HIV patient and her baby. Because the patient could not speak English and the instructions the nurse wanted to give her required engaged inter-personal conversation, lingua-franca and "touch ups" or "patch ups" would not have helped. I had conducted an interview with the nurse the day before so she knew that I could speak Shona. Therefore, faced with this linguistic dilemma, she asked me to explain to the patient the intricacies of using ART treatment for herself and her baby. The narrative description below describing what transpired deserves to be quoted at length:

> *I'm standing under the shade just opposite the maternal care ward, making phone calls. A nurse I've interviewed two days before rushes to call me to ask if I can come translate for her as her patient only speaks Shona and not English (God knows how many of these they get). When I walk in, the nurse tells me that, "I was afraid if I called in a patient it would affect confidentiality". I concur, because there are indeed lots of Shona speaking patients waiting for their turn to be treated. In the consulting room, I casually stand between the nurse and her patient who is holding a baby that looks 5 weeks old. Apparently, the mother is HIV positive but the baby has tested negative. The nurse asks me to explain to her that she musn't stop taking her ART treatment or giving the baby hers just because she has tested negative. I comply. The patient asks me in Shona to find out how long she will have to take her ARVS for. She doesn't even know that ARVs are lifelong treatment, I think to myself. The nurse says to me, "tell her she is now married to her ARVs". I translate for almost 10 minutes. After this, both parties seem satisfied. The nurse thanks me for my effort and I leave. I go back to the shade and I see that woman walking out of the facility with the baby strapped in front of her.*
>
> (Field notes, Vhembe, 31-10-2016).

Following this encounter, I wanted to find out how other health care workers dealt with language related challenges. The biggest question I had was, "do they have translator services?" The overwhelming response to this question, in Vhembe and Johannesburg, was "No". In Vhembe, as in Johannesburg, there was a consensus among health care workers that lingua franca that could be easily constructed during Venda-Shona interactions was impossible to construct between local health care workers and non-nationals from DRC, Malawi and others who spoke French and Swahili. According to my respondents, this hierarchy of difficulty left them no option but to rely on informal practices. For instance, one nurse described her dependence on

a member of the cleaning staff for translation, even though this meant risking litigation:

> *We don't have [translator services]. So we rely, like which language is it, which language? I've forgoten but there's this difficult language in Africa*[7]*. We have got somebody who is a cleaner who understands that. So which means we will have to call them. And the confidentiality around HIV, it's a challenge. Then the person can sue you again. It puts us in a very difficult position. It's where you have to weigh whether to assist the patient or adher to issues of confidentiality.*
>
> (Janet, Nurse, Vhembe, 29-10-2016).

One participant who claimed that he was originally from Zimbabwe admitted that he was often called upon by his colleagues to translate some foreign languages. He stated this view, which was confirmed by a colleague in a separate interview:

> *In fact me sometimes neh, I can patch up. You might find that in ANC that side they have got a patient they are not communicating well due to language problem. They can call me from that room to come and assist if I know the language. Because me at least I know many languages from different countries. So at least I can assist.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

> *Those who can't speak English, usually there is someone in the clinic who can understand like there's a guy who we work with who comes from Zimbabwe. So most of the clients here they come from Zimbabwe, so he would communicate with them.*
>
> (Beauty, Nurse, Johannesburg, 10-01-2017).

The use of informal translators was sometimes as random as asking a patient on the line who knew the patient's language to translate. As this Clerk in Vhembe had to say:

> ***Mulalo****: So we treat a lot of people from far away. Last time I remember I was treating this other guy with his wife and two children. They don't know how to speak English, they speak Swahili those people and French. But we were able to treat them.*
> ***KV****: How were you able to deal with that?*

[7] Once it occurred to her, the lady later told me that when she spoke about "this difficult language in Africa" she was actually referring to Swahili.

> ***Mulalo**: Fortunately there was a soldier guy sitting there on the queue. South African soldier guy. He said, "yeah, I think, I can see you are having a tough time there, let me help you, what's the problem huh?" They started to talk. He was translating when I was doing everything there. Because on that patient record file, you can't get it without a date of birth, you understand? And when I say date of birth, you don't know what to say. You just look at me, talk another term in French that I don't know. But that other guy helped. It almost took, four of them, almost 15 minutes to 20 minutes. And that's not how it's supposed to be.*
>
> (Mulalo, Clerk, Vhembe, 28-10-2016)

However, unlike Hunter-Adams and Rother's (2017) study, cleaning or health care staff playing the role of interpreter was not limited to assisting South Africans because in Vhembe, some staff could speak Shona even though they were locals, as in Johannesburg, where there were two Zimbabweans working in the clinic.

Experience with the public health care system shaped patients' responses to language difficulties. One nurse argued that patients who had long experience with their clinic already knew that health care workers there could not communicate with them because of language differences. Therefore, they routinely brought someone, either a friend or a relative, who could translate for them. The Nurse stated:

> *I think most of the ones who are from Zimbabwe, they speak in English, and especially the ones who are from Harare side, Masvingo. But the ones who are from Bulawayo side, they usually speak in Venda or Sotho, that way we do understand them. But those who are from maybe other countries like, we are having some from DRC and they speak in French, they usually come with an interpreter because they know that we can't hear them.*
>
> (Alois, Nurse, Vhembe, 3-11-2016).

This perspective resonated with the responses of several health care workers in Johannesburg who mentioned the primacy of relatives in translation during nurse-patient interactions. However, the trade-off was always patient confidentiality. Consider the following responses:

> *So what we do is either tell them to say, "if you don't understand any of the languages that are spoken in South Africa or English", cause mostly what I do is I speak with them in English. I say, "no, bring somebody who understands your language, a family member". The unfortunate thing is when you do that confidentiality changes now, there is no confidentiality now.*

(John, Nurse, Johannesburg, 17-01-2017).

> *We ask them to bring someone who will understand our language and their language because we can't give a service, proper service, if there's a language barrier. We ask for a member of the family to come along otherwise we are going to be doing sign language. They don't understand, if you don't understand. […] We normally get help when they bring someone who understands.*

(Bheki, Nurse, Johannesburg, 28-01-2017).

> *Some of them they come with somebody maybe aunty or cousin, or uyabona [you see], who can interpret for us.*

(Nonhlahla, VCT Counsellor, Johannesburg, 22-01-2017).

This finding illustrates Hunter-Adams and Rother's (2017) finding in Cape Town where their participants described accompanying their wives and partners to appointments to interpret for them. It is consistent with their view that it is common for family members to be used as ad hoc interpreters in the South African healthcare system.

In the first instance (above), I was fascinated by how Alois, a South African, could distinguish his clientelle's linguistic capabilites in terms of their places of origin. He portrayed an insider's understanding of the linguistic dispositions that different Zimbabweans possess. For example, Siziba (2015) found that the Ndebele from Zimbabwe were more able to negotiate linguistic differences, mainly capitalising on the similarity between the Ndebele and Zulu language varieties. Siziba's finding resonated with the perspectives of a majority of health care workers I interviewed in Johannesburg. However, in Vhembe, based on Alois' perspective, Siziba's argument that Zimbabwean Ndebele-speaking migrants have learnt the potentialities of their language and its connections with Zulu and used this as a form of capital by also deriding "marginal" ethnolinguistic groups such as Pedi, Venda, Shangaan and Sotho is questionable. This thesis does not adequately explain why "the ones who are from Bulawayo side [Ndebeles in Vhembe], […] usually speak in Venda or Sotho" (Alois, Nurse, Vhembe, 3-11-2016), and not necessarily Zulu. Perhaps, the explanation best lies in Ndlovu-Gatsheni's (2009) conceptualisation of the category Ndebele as a theoretical construct, possessing many meanings. Ndlovu-Gatsheni asserts that:

> This is a historical-pluralistic and inclusive definition of being Ndebele. IsiNdebele is the common language spoken by Ndebele although such other languages as Kalanga, Venda and Sotho were spoken too and are still spoken alongside isiNdebele (Ndlovu-Gatsheni, 2009: 13).

For now, it suffices to note that the politics of difference is sophisticated and this will be addressed in the following section.

4.3 A migrant workforce-clientelle: bureacratic incorporation and therapeutic citizenship?

> *Mind you, we don't hate migrants, okay. We love them.*
>
> (Alois, Nurse, Vhembe, 3-11-2016).

By way of understanding migrancy and the negotiation of difference between health care workers and non-national patients, it suffices to bring Alois' excerpt to the fore. The primary health care clinics I visited did not make appointments so they assisted patients in the order they arrived at the clinic. Therefore, the process of accessing health care services, from the point of registering with the clerk up until one received an audience with the nurse should be understood as one of negotiation. On my first day of fieldwork at the clinic in Vhembe, the Facility Manager glanced at the queue of about 350 patients and said, "You'll never know where they are from until you start treating them" (Field notes, Vhembe, 27-10-2016). This statement suggested that the community here was diverse, in terms of nationalities of origin, culture and spoken languages.

At the same time, it expressed a natural urge by the health care worker to neatly differentiate and categorise individual patients, while also exposing the inability or difficulty of the manager in differentiating her clientelle. But this was not surprising as the clinic in question was located in an area about 12 kilometres from the Beitbridge border. The people staying in areas around Vhembe mostly speak in Venda, Shangaan, Tsonga, Sotho, and most Zimbabwean non-nationals in Shona and Ndebele. The question of migration and access to health care services therefore cannot be divorced from an analysis of the politics of belonging, inclusion and difference.

4.3.1 Perceptions of a high cross-border migrant clientelle

First of all, there was a perception among health care workers in Vhembe and Johannesburg that most of their patients were cross-border migrants from "foreign nations", especially Zimbabwe. When asked if they got people who came for a short time just to access health services, many responded "yes". Indeed, there was a classic perception by some that cross-border migrants came to South Africa purely to access health care services. This illustrates Vearey's argument that popular South African discourse presents international migrants as placing an additional burden on the public health system based on presumptions that international migrant populations are far larger than they are (Vearey, 2012). Here are some of the responses to that assumptious effect by health care workers in Vhembe:

> *They come here for service. Many of them are here in South Africa, are here in this area. When they want to consult they come here to consult, they are here for service. […] There are some people who come here for a short period when they are in this area they come. They consult to us, after that go.*
>
> (Moyo, Nurse, Vhembe, 29-10-2016).

> *[…] in Zimbabwe I know it, they don't have most of the treatment. That's why they usually come this side.*
>
> (Dorcas, Facility Manager, Vhembe, 3-11-2016).

> *There are those that are coming for health services, there are those that are working. Like in Maroi, mostly when we go to Maroi, especially the farms along the river, there are people that are coming for health services only.*
>
> (Nancy, Nurse, Vhembe, 31-10-2016).

> *[…] they just like to come this side. [Laughs] That's the only reason that you can say. It's like they see us as people who are developed, who are having the health system that is better than them. Yah, that's why they travel. Because people are travelling monthly, from Harare. It's about 500 kilometeres from the border, coming this side to collect treatment.*
>
> (Janet, Nurse, Vhembe, 27-10-2016).

These perspectives were also resonant among a majority of health care workers in Johannesburg, who in particular believed that cross-border migrants came for services like ART and ANC. They opined:

> *We call them visitors. They might be coming from iLesotho but people who move around a lot are Zimbabweans. They move around a lot those people. Also Malawians yah, […] especially the Zimbabweans.*
>
> (Bheki, Nurse, Johannesburg, 28-01-2017).

> ***KV**: So do you think there are other people who come here for a short time just to access health services from other countries?*
> ***Nonhlahla**: Yes. Especially for ARVs neh.*
>
> (Nonhlahla, VCT Counsellor, Johannesburg, 22-01-2017).

> ***KV**: And do you think there are people that come here short term just to access health services?*
> ***Onias**: Yes, we do have people like that. And it's like all over South Africa and foreign people again, foreign nations.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

> ***KV**: Do you think you get people who come here just to access health care services?*
> ***John**: Yes. There's a lot of people, it's common from Zimbabwe. Yes, they come to deliver. After they've delivered children they go back to Zimbabwe. Because what I do […] we obviously tell them that do come back in 6 weeks for their injection, and the mother will say no I will be back at home then. "When did you come here?" "No, I've only been here a few days, a few weeks, I just came to deliver. I'm going back home".*
>
> (John, Nurse, Vhembe, 17-01-2017).

All these claims are not backed up by actual evidence. For example, existing data shows that most migrants tested HIV positive only after they had moved to South Africa (Vearey, 2008; Pophiwa, 2010). Vearey (2008) shows that a majority of non-citizen respondents (76%) in an ART access study had first tested for HIV in South Africa, and 80% had learned of their positive status in South Africa, indicating that migrants are often only testing and discovering their status once they are in the country. Moreover, a majority of international migrants travel to South Africa from a country of lower HIV prevalence (Vearey, 2008; Pophiwa, 2010) and are at greatest risk of infection once they have arrived in their host location due to highly likely behaviour change (Vearey, 2008). Rumours of pregnant women coming to deliver in

South Africa are also sensational, unfounded and based on a few media claims. As Vearey (2008) show, the most common reasons given for coming to Johannesburg were: economic opportunity (37%); to avoid war, violence or conflict (19%); and to find political freedom (13%). Health or health-care-seeking was not given as a reason for moving to the city, but access to improved economic opportunity and fleeing persecution (Vearey, 2008: 2012). Moreover, migrants are positively selected in that the majority are healthy and young (healthy migrant effect) (Vearey, 2012). Also, a "return home to die" effect was reported by Vearey (2012), consistent with other studies (Collinson et al., 2006; Clark et al., 2007; Collinson, 2010).

Besides the reasons provided above, the health care workers I interviewed in Vhembe and Johannesburg had other beliefs why cross-border migrants came to South Africa or their clinic to access health care services. Consistent with Vearey (2008), these respondents did not explicitly suggest that cross-border migrants came purely to access health care services. Rather, they portrayed a belief that people could have moved for other reasons like shopping and livelihoods seeking, then came to the clinic if they felt unwell in South Africa or along the way. This view resonates with the migration literature (Vearey et al., forthcoming; Moultrie et al., 2011) which shows that public healthcare users are mobile for reasons other than healthcare-seeking and there is no evidence of people moving in order to access healthcare. Some believed that their facility was attractive to internal and cross-border migrants because it was known as the main clinic. Therefore, they stated, if cross-border migrants suffered any ailments it was more likely that they would come to their clinic than any other clinics in the area:

> *Cause this is the main clinic whereby even nationally this clinic is very busy. Even province they know X clinic is very busy. So any person who think like is passing by and he wants to get treated, he will come here, because this is the main clinic near town.*
>
> (Mulalo, Clerk, Vhembe, 28-10-2016).

> *[…] let's say the Zimbabwean people, many of them they are passing, on their way. They can have headache whatever. It's the main clinic from border. If they coming from Joburg, the main clinic. The one that is in Y, it's outside, people don't know that clinic. They know this one, that's why they are too many.*

(Talent, Clerk, Vhembe, 31-10-2016).

> *You know some of them they said, "can I have them [ARVs] for such period of time then I'm going back to where I'm getting them?" Because they may be passing through Jo'burg.*

(Nonhlahla, VCT Counsellor, Johannesburg, 22-01-2017).

> *They can say you know what I visited my cousin here or I came to look after somebody who is sick or they come for a funeral or what and they discover that their date for treatment is due. So they go to local clinic with their appointment card and ask for one month supply to last them until they go back.*

(Onias, ART Facilitator, Johannesburg, 18-01-2017).

One participant believed that cross-border migrants came to their clinic because of the good service they rendered compared to others. He confidently concluded:

> *I can say it's the service. Because we offer them a good service and we get to listen to their stories, we get to understand but we get to make them do the right thing. […] I think it's the service. They like the service. Because some they'll tell you, "you know what I was at X" or" I was in this clinic" or where neh. They tell you you know what they said they can't help me because of […] to us I think it's the service.*

(Onias, ART Facilitator, Johannesburg, 18-01-2017).

This overall lack of consensus suggested that the belief that cross-border migrants were coming just to access health care services was not substantiated by concrete evidence as shown by existing literature (Vearey et al., forthcoming; Vearey et al., 2016). Rather, historically, South Africa has a high prevalence of population movements (Vearey et al., forthcoming).

To try and validate some of the assertions, I asked if health care workers could provide a monthly average and where they thought "these people" came from (i.e. internal or cross-border). The dominant view among health care workers in Vhembe was that most patients were from neighbouring Zimbabwe. But the claimed numbers were again inconsistent. These were some of the responses to this question:

We have too much Zimbabweans we treat in our facility. Most statistics are Zimbabweans if I compare, because each and every patient has to pass through me.

(Mulalo, Clerk, Vhembe, 28-10-2016).

They do come. More especially those who are living just nearer in the Beitbridge. They do come. […] my view since I came this side, we serve people from abroad unlike the local. The local they are few. Because even if you can take, most of them they are here for work related purpose. Those who are staying originally here in Musina, they are few.

(Sharon, Nurse, Vhembe, 29-10-2016).

We serve more than 3000 in a month. 95% are from Zimbabwe. 100% of the people that are at the farms are migrants. Because it either internal, 5% that I've excluded is internal migrants of course.

(Nancy, Nurse, Vhembe, 31-10-2016).

***KV**: Which place would they [patients] mostly come from?*
***Moyo**: [She points towards the Zimbabwean border before responding] Zim. [Laughs] Yeah this is the border line eh. Many of them is from there.*

(Moyo, Nurse, Vhembe, 29-10-2016).

It is curious that Mulalo claimed that "most statistics are Zimbabweans" when he also mentioned in another response that the Hospital Performance Report (HPR) system did not record nationality, or distinguish between local and non-national patients.

Unlike Vhembe, there was no consensus among Johannesburg respondents on where migrants were actually coming from. Rather, the emphasis seemed to be on the pre-eminence of internal migration. Where such knowledge was expressed, the implied figures were not that high:

We are actually serving more people from outside of Jo'burg. We are situated among the taxi ranks. So people get off the taxis to come and go back home. Different places. There's a lot of taxi ranks around us. I'm sure you've seen that neh? Here in front there's a taxi rank, there's a train station. On that side there's a few taxi ranks. Even behind here, all sorts of taxi ranks from different areas.

(John, Nurse, Johannesburg, 17-01-2017).

Per month like, let's say from other clinics in South Africa neh we can have like, plus minus fifty. From outside the country plus minus twenty.

(Onias, ART Facilitator, Johannesburg, 18-01-2017).

The nurse who initially claimed that pregnant non-nationals came to South Africa just to give birth argued that the numbers were not so high. However, he insisted that this was because non-national used hospitals for delivery instead of clinics. Referring to cross-border migrants, he opined:

It's not a lot of people that come here, but remember these people go mostly to the hospital, they deliver at the hospital and some of them immediately after delivery, a few days before they even come for three days they go back home.

(John, Nurse, Johannesburg, 17-01-2017).

But differentiating internal from cross-border migrants was described as a painstaking task. For Janet, this served no practical value in relation to adherence:

It's not far, it's not like it's more of, it can be 60% of our patients might be from that other side, from Zim, and 40% from this side. Also they are migrants. Akiri it's like we are dealing with the migrant, whether they are internal or they are from outside. Because with the defaulter rate you can't say it's less with our South African, because also they have just came from where they are coming from to look for work this side. So it's difficult to differentiate.

(Janet, Nurse, Vhembe, 27-10-2016).

This quote is essential in understanding the complexity of migration and who really is a migrant. In light of this compexity, it was not surprising that while some respondents in Vhembe specified the nationality of the bulk of their clientelle to be Zimbabweans, or provided hints by referring to locations like Beitbridge, others simply prefered to use the term "outside":

I can say the percentage of outside from here is too high, Because when we register here, […] when we captured monthly treatment, eish, they are many. From outside they are many. I can say 70 something percent are from outside.

(Talent, Nurse, Vhembe, 31-10-2016).

It was thus difficult to discern who the term "outside" was referring to, but given that the many health care workers associate the term "migrant" with non-nationals (Vearey et al., 2016) it is not difficult to see how the term may most likely relate to non-nationals. Another respondent could not provide a monthly average of cross border migrants they treated at their facility. Using her personal analysis of difference, through factors like language, she suggested that there were more cross-border migrants than locals that accessed services at the clinic:

> *[…] the fact is, we can't give these average as such, because that's why I said to you, they register with our addresses around here. We just recognise them by their languages, or the way they get to try to speak our language. I can say to you that you are not from here, because I can understand the way they talk or I can hear the tone of that person, that this person is not from South Africa exactly. But we have lots of them that are consulting, more than those that are here.*
>
> (Dorcas, Facility Manager, Vhembe, 3-11-2016).

Language was being used by Dorcas as a marker of identity, and this illustrates McCarthy et al.'s (2009) argument that the language and accent of foreigners are reportedly easily distinguishable from citizens. The strategy to identify migrants was consistent with Lipsky's (2010) finding that street level bureaucrats like the police may find clues to the identity of a potential assailant in a person's walk, dress, style of car or composure. But these cues are not always accurate. Therefore, overall, it was difficult to get a clear understanding of the actual number of cross-border migrants accessing health care services vis-à-vis locals and internal migrants. Moreover, it was difficult to discern where the patients in each clinic were coming from. There are a lot of cross-border and internal migrants living in Vhembe and Johannesburg which has implications on conclusively identifying who a migrant is using language and phenotypical features among others. Therefore, all the above estimates are at best merely anectodal.

4.3.1.1 Does this perceived cross-border migrant clientelle affect services for locals?

Despite the conviction by most health care workers that cross-border migrants were coming to their facilities to access health care services, there were mixed feelings on

whether this affected services for locals. Some felt that migrants did not affect health care services for locals, and since Vhembe was a border town, DoH provided enough to accommodate migrants:

> *For now I don't think they interrupt anything. Because they know, even nationally when they send medication they count them. They know kuri this town, people pass through here. It's either border jumping, it's either straight straight passing through or on top. They know this is a border town.*
>
> (Mulalo, Clerk, Vhembe, 28-10-2016).

The responses to this question were similar in Johannesburg, but more unanimous. Five nurses responded to this question, and three of them understood access to health care services as a zero-sum game. One of them there argued:

> *Unfortunately when we order our stock we order based on our headcount you see. How many people do we see a month? And obviously we measure to say, "okay if I immunised a thousand babies when I order my vaccines I'll probably order a hundred extra to make sure that it's covered". Next thing I've got people from other places whom I gave the vaccines to and the locals don't have.*
>
> (John, Nurse, 17-01-2017).

John's response contrasts markedly with Mulalo's. But, one nurse in Vhembe who claimed that they did not run short of treatment, a response which resonated with Mary and Beauty from Johannesburg who challenged the perspectives of John and other colleagues suggesting otherwise:

> *There's nothing [effect], but you could just think kuri if this population was not there maybe the money will be taken to do something better for us. But there's no problem because we are not running short of treatment. We have got a lot of them coming but we are not running short of treatment.*
>
> (Janet, Nurse, Vhembe, 27-10-2016).

> *There is no pressure because the government is supplying the treatment. Other people they feel like they are working for them. It's a few South Africans who come to the clinic, it's most migrants, but the government understands. Yeah, they understand. They are advising us that we must help them.*
>
> (Mary, Administrator, Johannesburg, 22-01-2017).

We never run out of treatment. Even if know that today it's Friday and this treatment is supposed to last me till Sunday and I run out, by tomorrow they deliver. It's not a problem that I run out of medication then I send the patient away. There's always something to give. Even if we can give one month's treatment, but there is always something to give. I've never run out that, "come tomorrow I don't have." I've never had that.

(Beauty, Nurse, Johannesburg, 10-02-2017).

Again, the lack of consensus reflects the lack of concrete evidence on this presumed effect of cross-border migration on health care services.

4.3.2 A migrant workforce

In Vhembe, most of the health care workers I interviewed were either long-term internal migrants or travelled long distances weekly to work. In Johannesburg, one participant identified as an internal-migrant, while two admitted that they were originally from Zimbabwe. To understand the concept of migrancy in greater context I drew explicitly from a question asked in the ACMS and LSHTM 2015 study (see Vearey et al., 2016). I asked my participants the question, "are you originally from this area?" In Vhembe, these were some of the responses:

I'm not originally from this area. Yesterday we were at Makhado, that's my town. I'm from Cherere, and I travel really to come this side, about 160 [kilometers] return daily.

(Janet, Nurse, Vhembe, 29-10-2016).

I'm from Mutale, its too far from here. We use the town of Thohoyandou when we go for shopping, There is Mutale that side, Chiramba. I got up early. Half past four I was in taxi then I got here half past 7 to 8, it's 3 hours. I go there on Friday, I come back on Sunday. But yesterday the bus came late. Past 2 didn't come, so I went back home, then I woke up early in the morning. I can't use early in the morning because I wake up on 4 o'clock, so that I reach the time of the work.

(Talent, Clerk, Vhembe, 31-10-2016).

***Sharon**: Home, I come from Elvadesia which is under Louis Tritchard Municipality, Makhado. […] So that one it's our hometown, but our nearest hospital is Elim Hospital.*
***KV**: So are you also a migrant, you move quite a lot hey, internally?*

***Sharon**: [Laughs] Yeah so when I'm on duty, I stay here and when I'm off I just go home. My off days I spend them at home. So here, I'm here only for work, coming to work and then off to my home then, just like that.*

(Sharon, Nurse, Vhembe, 29-10-2016).

In Johannesburg, three participants (one internal and two cross-border) identified themselves as migrants. They stated:

Akiri obviously we are all migrants. So I migrated from the North West long back, but that was 20 years back. […] I've been working in Joburg for the past 11 years. […] For the past 11 years I've been all over Jo'burg. […] I've worked in Gauteng […] and I'm mobile.

(John, Nurse, Johannesburg, 17-01-2017).

I'm a Zimbabwean. I came from Zimbabwe.

(Onias, ART Facilitator, Johannesburg, 18-01-2017).

I've been working for the City of Jo'burg since 1997. Yeah. Originally I come from Zimbabwe, in Bulawayo.

(Mary, Administrator, Johannesburg, 22-01-2017).

Some health care workers claimed that there was no real difference between themselves and cross-border migrants when asked, "do you consider yourself a migrant?" In probing further, I would also ask if health care workers thought there was any difference between "us" and "them". To those that responded to this question, there was a unanimous acknowledgement of some form of migrancy, although different in a few nuances. This was one of the perspectives of one Vhembe nurse on the issue:

***KV**: Do you consider yourself a migrant?*
***Jane**t: [Laughs] That's a difficult one. Yes, maybe I am [she laughs again].*
***KV**: You think you are?*
***Jane**t: Yes, I think I am.*
***KV**: So if you see somoeone who is from across the border compared to yourself, and you say you are a migrant, are you the same?*
***Janet**: I don't see any difference between us. The only difference it will be maybe that somebody will not have anywhere to sleep tonight, but nah I'm having somewhere that I will sleep, but there's no any other difference between us and them. To me there is no any difference.*

(Janet, Nurse, Vhembe, 29-10-2016).

Others' understanding of migrancy was in fluid terms. This Vhembe clerk defined a migrant in relation to his own experiences, and submitted:

> *A migrant is a person who can travel from one place to another seeking for better life. That's how I understand migrant. […] for now I can say I'm a migrant cause I'm still seeking for a better life. Here I came with an NGO. Yes, I'm also from around but I'm still seeking for a better life. Maybe I can get a job in Polokwane, I can still go there, in terms of salary, connects and stuff like that.*

(Mulalo, Clerk, Vhembe, 29-10-2016).

Mulalo's suggested that a "migrant" was a state that is "never in completion", but dynamic. He understood the term "migrant" as a temporal construct that is unstable as seen in his use of the term "for now". There seemed to be a relationship between these inclusive understandings of migrants and the way they treated non-nationals, as will be discussed below.

4.3.3 Bureaucratic incorporation and therapeutic citizenship?

Interestingly, there was a relationship between migrancy and how health care workers treated or viewed cross-border migrants. My interviews and observations unearthed a politics of inclusion and bureaucratic incorporation (Marrow, 2012; Walter and Schillinger, 2004) in which frontline health care workers came to see immigrants as simply another set of clients, and acted "to provide services to them much as they would to any other clients" (Gell-Redman et al., 2014: 2). In terms of access to ART treatment for cross-border migrants (undocumented, without referral letters sometimes), the decision by frontline health care workers in Vhembe and Johannesburg was based on moral deservingness (for example through an evaluation of the nature of the body's frailty and age), rather than nationalistic contingencies. These determined who got access first, and to what (Birkland, 2015).

In an ambivalent system that pushed them to deny care through "hidden bureaucratic barriers" (Marrow, 2012: 847), an action incosistent with their values, I found instances of individuals struggling to cope and resist, subscribing instead to an ethos

of "what is right for the patient" (Walter and Schillinger, 2004). Belonging, deservingness and access to the health care institution and the services thereof were constructed around - to a certain extent - a "therapeutic citizenship" divorced from the legality and documentation status of so-called "migrant bodies". There were other extralegal means through which access was negotiated by sometimes ignoring statutory modes of registration. This resonates with Marrow (2012: 847) who found that unauthorised immigrants had de facto legitimacy to be part of San Francisco's civic community, based on a conception of local "inhabitance" or residence (e.g., *jus domicili*) rather than birthright, ancestry, or legalistic citizenship. The questionability of the currency of documentation to how cross-border migrants access health care services in South Africa has not been adequately dealt with in the existing South African literature.

Indeed, the politics of difference themselves are complex and often contradictory (Kirkham, 2003), and in the context of my research, inclusion drew from different rationalisations. A middle aged Clerk explained her reasons in terms of her marriage to a foreign national:

> *Myself, I can say, I take every person we are the same, because I was married. My husband he came from Malawi, so I understand every person. Others […] you will see they call Zimbabweans whatever. But on my side, even now I'm staying with someone who is Shona. She is a woman, she have a shack in my house, so you see, yah, I don't have any relatives here. So I can't take a side, because even me I'm not from here, we came far. We are the same Shona, Venda, because its not our side here, we just came for work.*
>
> (Talent, Clerk, Vhembe, 31-10-2016).

For others, while the patients' names helped them differentiate between non-nationals and locals, perceived ethnic ties created by a history of inter-generational migrations were such that, citizens living in the border town of Musina often had the same names as Zimbabweans. Mulalo's response invoked some loyalty or allegiance to provide and ration services on this basis. This is how our conversation on the matter ensued:

> ***KV**: Does the fact that you are a migrant shape how you treat other migrants?*
> ***Mulalo**: Yah, yah**.** […] our dashboard HPR doesn't show uri you are a foreigner or what, but by names you can see. And still by names we can't because here is a border town. We are a grandchild of a Zimbabwean,*

because we have Tawanda[8] in lokshin, he was born near Musina by the name of Tawanda kwaTlou.

(Mulalo, Clerk, Vhembe, 29-10-2016).

Other Vhembe respondents found it very difficult to discern who was a non-national because, they alleged, some cross-border migrants had South African IDs and in some instances spoke the local languages. However, there was also an expression of some phenotypical method they used to discern where a patient was from. Dorcas opined:

***Dorcas**: Most our patients are from that other side. The only challenge is that we can't identify them.*
***KV**: You can't identify them?*
***Dorcas**: Because what we do, we were considering that if you have a green bar coded ID you are South African, but you can find a person having that green bar document who can't even utter any word from this side in South Africa. You can see kuri this person is from Zim. So it's very difficult to know who is internal and from outside.*

(Dorcas, Facility Manager, Vhembe, 3-11-2016).

I was able to use my positionality as a Shona researcher in South Africa to elicit a personalised understanding of how difference was understood in Vhembe. As a matter of personal principle, I would always inform my participants of my nationality before starting an interview. As I was concluding one interview, a female nurse asked me: "Where do you come from, Zim?" This is how I responded and how the rest of the conversation went:

***KV**: I'm a Zimbabwean.*
***Moyo**: From which part?*
***KV**: KweKwe, in the Midlands Province.*
***Moyo**: Tongai Moyo [she starts dancing]. I like Tongai Moyo's music.*
***KV**: [I laugh] I'll bring you Tongai Moyo's music.*

(Moyo, Nurse, Vhembe, 29-10-2016).

Tongai Moyo was a legendary Zimbabwean musician in a genre called sungura music who grew up in a small city called KweKwe in the Midlands Province, Zimbabwe. This conversation fascinated me because I was not expecting to find a nurse who

[8] Tawanda is a popular Shona name

loved his music so devoutly, to a point of expressing this to me. This "cultural connectivity" convinced me that these could be other grounds for the exercise of deference and inclusion in this space. The space which Vhembe lies has a close proximity to neighbouring Zimbabwe and is an illustration of the temporality of colonial borders. Whatever the grounds for social exchange were, issues of nationality and documentation were not contingencies. Rather, it appeared that there were ties related to past migrations from both sides of the border that cut across several generations that created some cultural commonality, or imagined homogeneity. In my view, these ties still held intricate ethical value. For example, in my stay in Vhembe, it was common to hear Venda speakers address cross-border migrants in Shona, having friendly conversations. This phenonemenon is partly explained by Bakewell's argument that:

> The borders imposed by colonial powers cut across many ethnic groups and in many cases the people of the frontier areas have a loose relationship with the distant state whose authority is frayed at its edges. The people of different nationalities on either side of the border may have more in common with each other than either group has with their corresponding co-nationals from the capital (Bakewell, 2000: 2).

Even though Bakewell's argument was premised on refugees, it raises bigger questions of how access to health care services, and provider-patient interactions are mediated by the geo-political, historical and cultural symbols, resulting in bureaucratic incorporation.

On the other hand, Johannesburg is generally dominated by the Zulus and Xhosas in terms of composition and language. Groups such as the Venda, Shangaan and Tsonga with their languages are often marginalised (Siziba, 2015). It is not rare to meet people in everyday experiences who bemoan the difficulty of these languages, likening them to Shona. But, drawing on my analysis of Vhembe data, I became interested in the position of two Zimbabwean health care workers and how their origins influenced their approach to non-nationals accessing ART treatment. Partially, the respondents stated that they were aware of their positionality, but they did not portray this as their motive for facilitating access for cross-border migrants. Instead, they argued that they treated everyone the same:

According to me, me I treat everybody equally, fairly. Yes we know we are in a foreign nation so it's not our nation. That one we understand. But, according to me, I treat everybody equally.

(Onias, ART Facilitator, Johannesburg, 18-01-2017).

I'm part of a worker here. I'm not presenting a certain type of people [migrants]. I'm presenting the community, working for the community of Ward [X] in [Y]. Everyone who comes to this clinic has a right to health care. So I'm presenting everyone who comes to the clinic. Treating everyone the same, there is no difference.

(Mary, Administrator, Johannesburg, 22-01-2017).

Therefore, migrancy in Johannesburg was not closely related to the bureaucratic incorporation of cross-border migrants at the clinic as was the case in Vhembe. Rather, to some extent, I found that "therapeutic citizenship" – "a form of stateless citizenship whereby claims are made on a global order on the basis of one's biomedical condition, and responsibilities worked out in the context of local moral economies" (Nguyen et al., 2007: 142) - played a more prominent role in facilitating access to ART patients. My understanding of Nguyen et al.'s concept was nuanced in relying solely on the perspectives of health care workers – an issue I resolve later on - but, this finding is consistent with Wilhelm-Solomon's (2013: 228) finding in Uganda where "HIV-positive camp residents developed social relationships around their shared biological condition and through therapeutic practices". Wilhelm-Solomon (2013: 232) conceives HIV-based social relations as a "biosociality", which "arises from belonging and identity based on a biological condition and shared therapeutic and diagnostic practice. New HIV-based support groups may use their disease status to refashion national or transnational conceptions of rights, citizenship, and entitlements".

Likewise, faster access to treatment was contingent on theraupetic and diagnostic practice and discipline; the ability to capitalise on one's medication through treatment adherence. So regardless of nationality or legality, discipline and treatment adherence over a long period was described by health care workers I interviewed as crucial, forging new subjectivities (Wilhelm-Solomon, 2013) of belonging. The concept of "adherence clubs" was deployed in order to foster this and facilitate faster access for "disciplined bodies". Their access to ART was fastracked compared to others,

because these patients would find their files and medication prepared, without having to wait in queues which were often long. As the ART Facilitator coordinating them opined:

> *So all those patients that are stable, we take them, we put them in the clubs. In the clubs it's fast cause they find their medication being prepared day before, and their files being prepared, being retrieved day before. So when they come there's a head count, we give them a health talk, from there, we give them their treatment. Then they leave. […] We know they are going to spend a lot of time here at the clinic because they have to do bloods and medication. So you find out that they spend 2 hours because most people of the club they are not ollowed to spend more than 30 minutes at the clinic. Because everything is being prepared.*
>
> (Onias, ART Facilitator, Johannesburg, 18-01-2017).

This shows that not all health workers in every situation practice differential treatment in a way that puts vulnerable patient groups at risk (Andersen, 2004). But, "belonging" to this "therapeutic enclave" was only earned through what one nurse described as "graduating" through patient stability. Only patients who had been adherent to treatment for a year or more could join these clubs. This is what Lipsky (2010: 107) has called "creaming", a process whereby, "confronted with more clients than can readily be accomodated street level bureaucrats often choose (or skim off the top) those who seem most likely to succeed in terms of bureaucratic success criteria". This finding is consistent with Lipsky's (2010) view that street level bureaucrats often respond more favourably to clients who are helpful or cooperative in their own treatment, orienting services towards cooperative clients, or clients who respond to treatment. As my respondent stated:

> *If they are good, they keep their appointments, they are adhering to their treatment for a year or more, we refer them to the proper adherence group. We call them adherence clubs. Those are the ones I would say graduated from basic challenges. So those are the better ones who are, the bloods are good, and then they are healthy, and then they keep their appointments, and then those are, they belong to the adherence club. So it's like a graduation.*
>
> (Bheki, Nurse, Johannesburg, 28-01-2017).

Overall, inclusion was not only institutional but also interpersonal. For example, in the adherence club, Nguyen et al.'s concept of "confessional technologies" (Nguyen

et al., 2007: 133) was invoked as I found that the clubs offered motivational support between locals and cross-border migrants. In the club:

> *[…] that's where they motivate each other. Maybe they will meet twice a year. We formulated clubs because we wanted to encourage them not to default treatment. What are benefits of belonging in a club? When you come in the morning if there are 200 patients, if you come you don't queue you just walk in and take your treatment. Who qualifies to belong in the club? The person who is virally suppressed, the person who is responsible who knows that I must take my medication, they don't need to be monitored as much as the new one.They communicate in Whatsapp groups. They enjoy to be in the clubs. You'll find even the new ones that just started asking, "when are you putting me in the club?" They look forward to be in a club.*
>
> (Beauty, Nurse, Johannesburg, 10-02-2017).

Consistent to Nguyen et al.'s findings (2007), confessional technologies were used by health care workers as a means of fostering mutual support and, in a context of stressed primary health care facilities in which patients had to wait long queues to get treatment, they could select those who could best benefit from obtaining medications. This fostered an institutional culture that enabled "in Foucaultian terms, disciplined patients" (Nguyen et al., 2007: 139; Wilhelm-Solomon, 2013).

However, this finding is not in itself conclusive. As I conducted research with health care workers and not patients per se, the claim is not easily sustainable with the available evidence as the voices and claims of the patients themselves are not documented. If this analysis is to be developed further, further research with patients at the same institution will be required.

4.4 Blurred policy spaces and "grey areas in-between": Identifying policy gaps and cases of policy innovation

4.4.1 Analysis of existing policies

Policy-makers are coming to grips with the idea that South Africa cannot achieve positive health outcomes for its own citizens while neglecting those of vulnerable migrant communities (HRW, 2009: 3). However, policy responses to communicable diseases and other non-communicable ones have not adequately engaged with

mobility (Walls et al, 2016; Vearey, 2014). In my policy analysis, I found that a number of polices were incomplete or inapplicable to mobile patients, which explains why frontline discretion was largely unavoidable. Moreover, multiple pieces of legislation and guidelines proved confusing (Vearey, 2012: 61-62).

Indeed, healthy migration is good for development but migration is rarely formally well managed in the region (Vearey, 2014). While it is important to recognise that SADC member states have all adopted "clear policies and programmes to deal with communicable diseases for their population" (SADC, 2009: 7), in South Africa and elsewhere, deliberately, these do not extend to cross-border migrants. Even nationals who are covered by such policies and programmes, where they exist, also face similar challenges in terms accessing these services. Faced with overburdened public health care systems (Crush and Tawodzera, 2011; Walls et al., 2016: 14), policy responses that overlook mobility present many challenges, specifically for controlling communicable diseases in South Africa and the region. It is possible that such policy gaps also contribute to Southern Africa's highest burden of HIV/AIDS and TB in the world (Matjila et al., 2008: 90).

There is no official state policy to harmonise ART treatment for properly and formally managed continuity of care for mobile populations, in South Africa and across the SADC region (SADC, 2009; Walls et al, 2016; Vearey, 2014). Besides the existing literature, this "grey area in-between" (McConnel, 2010) was reflected in several responses including these:

> *We don't have a policy to do that, you need to use your own discretion.*
>
> (Nancy, Nurse, National Consultation on Migration and Health, Johannesburg, 22-11-2016)

> *The systems are poor at the moment. And for them to get the systems right we must go back to the beginning. That's the problem, it's going to be even more costly now.*
>
> (John, Nurse, Johannesburg, 17-01-2017).

In the very first place, South Africa took a belated decision to provide ART, but it now has the largest treatment programmes in the world (Karim et al., 2013).

However, South Africa is still currently underperfoming in it efforts to control HIV as it fares worse in comparison to neighboring countries (Karim et al., 2013).

Domestically, clauses in policies like the Patients' Rights Charter entitle "everyone" to access health care services including patients living with HIV or AIDS. But, the issues of population mobility are not adequately addressed in existing policy responses. Certainly, the Patients' Rights Charter (3) contains a "continuity of care" section. While this is notable, it only addresses the point that, "no one shall be abandoned by a health care professional worker or a health facility which *initially took responsibility for one's health*" (italics mine). In saying this, the document only addresses sedentary populations by framing continuity of care as the responsibility of the initial facility while ignoring the role of other "receiving" clinics of mobile populations who want to continue with ART treatment in a new locale.

ART treatment is vital to migrants' livelihoods (Vearey, 2008). Realising this, the state has taken some considerable steps to deal with the needs of mobile populations, but this view was not reflected in the responses of most participants, suggesting that these have not been enough. There are some policy attempts that were made by DoH in 2006. In a statement, DoH reminded healthcare providers that denying migrants without a South African national identification document to access ART is unlawful (Crush and Tawodzera, 2011). Going a step further on its initial statement, in 2007, the DOH issued a directive that asylum seekers and refugees could now access ART treatment free of charge (Crush and Tawodzera, 2011; Vearey, 2012). But, the 2007 DoH directive was distributed in an *ad hoc* manner, often to district health offices where staff were asked to "make copies and pass on" (Bateman, 2010). This meant that, where this happened the directive was often smudged and illegible, and this was compounded by the lack of subsequent monitoring and evaluation by the DoH on the directives' impact or any training or follow up to ensure that legislation was actually carried out (Bateman, 2010). According to IOM (2013: 22), "The National Strategic Plan on HIV, STIs and TB, 2012–2016 considers migrants as a key population and gives migrants access to antiretroviral therapy (ART)". However, the most recent National Health Insurance White Paper (2015) does not adequately address mobility and equal access to public health care for cross-border migrants. This poses public

health threat for controlling communicable diseases that require early diagnosis and treatment like TB and HIV.

Such policy ambivalences and double standards, poor implementation, monitoring and assessment throughout the system have undermined the Ministry of Health's sometimes-good policies (Coovadia et al., 2009). The stark contradiction that exists between Section 27 of the constitution and South Africa's national health policies regarding access to public health services like HIV testing, diagnosis and treatment for cross-border migrants, notably the NHI, has created a policy "blurred" space or "grey" area that compounds the difficulties already created by a high burden of disease, low resources and access challenges in public health care facilities.

At a regional level, the SADC Framework for the Control of Population Mobility and Communicable Diseases, originally drafted in 2009 (Vearey, 2014), attempts to create harmonious systems for continuity of care. However, South Africa has not yet approved or ratified this document (Vearey, 2014; Vearey et al., unpublished). Suffice it to say, there is a lack of nationally and regionally co-ordinated strategies to ensure treatment continuity for chronic conditions as a result (Vearey, 2014). Inadequate regional harmonisation and coordination lead to sub-optimal cross-border patient referral services. In other words, and as reflected in my interviews, patients "get lost to health systems when they are cross borders and may be re-started on treatment as new patients thus increasing the chances of drug resistance and sub-optimal outcomes" (SADC, 2009: 7). Both challenges bear negatively on public health by increasing transmission risks of drug resistant HIV strains (Goudge and Ngoma, 2011).

Supplementing the DoH ART guidelines (Vearey, 2012), non-state actors have too attempted to complement the state's "incomplete" efforts by also framing their own policies. In 2007, the UNHCR and Southern African HIV Clinicians Society issued clinical guidelines to "clinicians, non-governmental organizations (NGOs), and governments on the provision of antiretroviral therapy (ART) among displaced populations" (Vearey, 2012; UNHCR, 2014: 5). MSF piloted the patient health passport in Vhembe in a bid to harmonise patient health records (see MSF, 2012). In 2014, UNHCR and the Southern African HIV Clinicians Society released updated

guidelines stressing that migration and displacement status must not be used as excuses to deny these groups ART treatment (UNHCR, 2014; Mendelsohn et al., 2014). Again, this was a bid to ensure access and continuity of ART treatment for migrants and displaced persons (UNHCR, 2014). They specified that all displaced persons have a right to access ART. However, none of these guidelines are binding on the state therefore, many challenges continued to be experienced by international migrants when they attempt to access public health services in South Africa, as protective policy has not been effectively transformed into protective practices (Vearey, 2012).

It is disconcerting that some actors involved in framing national responses to HIV like South African National AIDS Counci (SANAC) demonstrate little knowledge about the need to include human mobility under social and structural drivers for HIV in South Africa. SANAC was established in 2000 to provide policy direction and implementation of various HIV interventions, to monitor progress, outcomes and impact of these interventions (Matjila et al., 2008: 92). However, during my observation, I found that limited progress was reported on including migration as a key intervention area, and few displayed interest, with more focus being given to an AIDS resilience model which stresses the individual's ability to manage risk (Social and Structural Drivers of HIV Technical Working Group minutes, 28 September 2016).

Post-apartheid policy visions have also been constrained by inadequate planning, poor stewardship, leadership and management (Fonn, 2011; Sanders and Chopra, 2006), limited capacity and understaffing (Segatti, 2014). Karim et al. (2013: 926) argue that South Africa is not deficient in policy, but rather lacks either the will or the capacity to deliver. These factors have compromised the ability to deliver key programmes and policies for HIV and TB (Coovadia et al., 2009). "South Africa's response to the epidemics during the past decade has been marked by denialism, ineptitude, obtuseness, and deliberate efforts to under- mine scientific evidence as the basis for action" (Karim et al., 2013: 921-922). While there is extant data that can be used to shape informed policy responses, South African scientists have had few, if any, opportunities to provide and interpret the available data for policymakers and planners for either epidemics. (Karim et al., 2013: 928). Indeed, unwillingness at the highest

levels of government to address HIV and AIDS has effectively led to policy confusion and programming delays (Kautzky and Tollman, 2008).

There are several policies that address the issue of access to health care services (see table 3).

Table 3. South Africa health policies, provisions and identified gaps

Policy	Provisions for migrants	Identified gaps
Section 27	Section 27(1) of the constution guarantees the right to access health care services for all (Vearey, 2012). Section 27 (2) further imposes an obligation on the state to take reasonable legislative and other steps, within available resources, to ensure the realisation of this right.	The clause on "available resources" is open to interpretation and is often used by health care providers as a scapegoat to deny care to undocumented migrants (see Vearey et al., forthcoming).
National Patients' Rights Charter	It states that everyone has the right to […] health information on the availability of health services and how best to use such services. The charter must be obeyed by every hospital and clinic in the country. Persons living with HIV or AIDS patients fall under a "special needs" category of the Patients' Rights Charter. Under this clause, everyone has a right to access of health care services that include among others: provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients.	It contains a "continuity of care" section which only addresses the point that, "no one shall be abandoned by a health care professional worker or a health facility which *initially took responsibility for one's health*" (italics mine. Therefore, it only addresses sedentary populations by framing continuity of care as the responsibility of the initial facility while ignoring the role of other "receiving" clinics of mobile populations who want to continue with ART treatment in a new locale.
Refugees Act	Refugees are entitled to the same access to treatment and "basic health care services" as citizens in public health care facilities (Section 27 (g) of the 1998 Refugees Act). The same also applies for undocumented migrants who are citizens of any SADC country.	
National Health Act	Primary health care facilities (clinics and community health centres) must provide free care to everyone, except for people covered by medical aid schemes, or receiving payment from the workers' Compensation Fund.	

South Africa's segregatory history also had profound implications on the country's current health policy frameworks (see Coovadia et al., 2009; Karim et al., 2013). This does not suggest that policy decisions by the post-apartheid state have not contributed. Such a conclusion would be misleading, as some scholars have comprehensively shown how a history of antagonism between the government and the intended beneficiaries of its HIV/AIDS control programme has impeded both policymaking and implementation (Karim et al., 2013). Others have made reference to Thabo Mbeki's "flirtation" with AIDS dissident scientists, his public statement about the links between HIV/AIDS and poverty, and Jacob Zuma's controversial statements (e.g. the shower statement during his rape trial in 2005) which have been taken up in policy debates (Oostendorp and Bylund, 2012: 78). But in all this plethora of existing tensions between HIV and health care, migration is rarely invoked in the equation.

4.4.2 Navigating these "grey areas in-between"

In interpreting policy, health care workers in Vhembe and Johannesburg argued that the lack of guidance, unclear structures and poor policy coordination made it difficult for them to effectively respond to the needs of mobile ART patients- internal and cross-border alike. Policy means different things to different people (Walt, 1994). As such, I was interested in knowing how health care workers understood the term policy, therefore I asked a clerk, "How do you understand the term "policy". The response was:

> *Policy is insurance contract. To me it's an insurance contract. It's a programme, it's a procedure which has has to be followed on a particular […unclear …]. That's what I get, that's what I understand the word policy.*
>
> (Mulalo, Clerk, Vhembe, 28-10-2016).

The above definition is reflective of two understandings of policy. One is that of policy as "insurance" as cover, and the second one is policy as a "programme" or "procedure". When I probed further to ask Mulalo if his work with cross-border migrants was guided by any policy, he remarked, "For my work no. But yes I know the insurance policy" (Mulalo, Clerk, Vhembe, 28-10-2016). In order to allow for a more discursive and dialogic learning of how the term policy was constructed in the

lived experiences of health care workers, I interpreted the meaning from various responses to questions relating to policy. This helped to elicit a contextual meaning, as opposed to a merely technical one.

In order to respond to these grey-areas of policy, health care workers stated that they had come up with their own ways to deal with cross-border migrants requiring ART. Recent research suggests that, in lieu of formal policies and programmes, frontline healthcare workers are finding ways to innovate to support healthcare access for migrants – particularly in relation to facilitating continuity of care to HIV treatment (Vearey et al., forthcoming). Beyond what the existing literature has found (the piloting of "health passports"; an ART referral protocol for migrants moving between South Africa and Zimbabwe; and the provision of ART through mobile clinics to migrant farm workers in Limpopo and Mpumalanga), in the case of Vhembe, these spanned from personal discretion, developing self-owned systems and ideas at a facility level and initiating dialogue to address these policy gaps at a sub-district level in forums like the Vhembe-Beitbridge Cross-border HIV/AIDS, STI and TB Technical Coordination Forum and the Migrant's Health Forum. Health care workers demonstrated that they were not passive recepients or implementors of policy, but they also contributed to policymaking by initiating certain ideas and practices to deal with policy problems (Walt, 1994; Young and Gaunt, 2014; Henderson and Pandey, 2013; Hoyle, 2013; Finlay and Sandall, 2009; Walker and Gilson, 2004). In a demonstration of policy agency, when one nurse explained her role at a clinic in Vhembe, she stated:

> *We have been working as mobile providing primary care service although when I arrived HCT and TB were not managed in the institution. And then I had to sit down and come up with a strategy of how best can we start.*
>
> (Nancy, Nurse, Vhembe, 31-10-2016).

Informal practices "effectively become public policy, rather than the intentions or objectives of documents and statements developed at a central level" (Walker and Gilson, 2004: 1252). There were a lot of conflicting responses on whether DoH provided training, policy or guidelines on how to treat cross-border migrants without referral letters or IDs, as found in other studies. In Vhembe, health care workers

claimed that they had to find ways of addressing dilemmas, without any knowledge on what to do with cross-border migrants requiring ART. Two respondents, both Clerks, highlighted that they had only received some training about migrants at their previous occupations. They did not recall any training from DoH at their current clinic. Our conversations ensued as follows:

> ***KV**: Did you receive any training on how to treat migrants on ART?*
> ***Talent**: No I'm just doing it, I didn't receive any training.*
> ***KV**: Did you receive any guidelines from the Department of Health?*
> ***Talent**: I did it at the clinic that I was working. They did come the people came from the Department of Health. They were five. They told us that they will give us the books to read but then they didn't give us. We are just trying, without knowledge.*
>
> (Talent, Clerk, Vhembe, 31-10-2016).

> ***KV**: Did you receive any training on how to treat migrants on ART?*
> ***Mulalo**: No, not from the department, from my previous work, from Red Cross. We've been trained to treat migrants, to deal with them. […] When I was at Red cross we were trained, we were trained about the migrant.*
> ***KV**: Did you receive any guidelines from the Department of Health?*
> ***Mulalo**: Yeah cause I remember last time, we have visitors from national, we have visitors from province. There's a one other lady, a high profile one; she said, "hey hey you, you have to treat these foreigners well, these are our bosses". That's where I get my knowledge that yah, she's right. But there isn't anything written down.*
>
> (Mulalo, Clerk, Vhembe, 28-10-2016).

Talent claimed she had not received any training on treating migrants on ART. In terms of guidelines, her response was doubtful and suggested that DoH may have approached them but this did not materialise into any formal, operational guideline. Altogether, she concluded, these efforts had not improved her knowledge on how to deal with cross-border migrants. Rather, she was "just trying" to make it work. Similarly, Mulalo only received training about cross-border migrants on ART from his previous job at Red Cross. The guidelines he received from DoH were his inferrences from the statement issued by the "high profile lady" from National on treating foreigners well. These do not amount to anything officially prescriptive or binding in the formal operational sense.

Similar uncertainity was expressed by some health care workers in Johannesburg. Like Mulalo above, one respondent made reference to speeches as ways as the only thing close to policy or training on migrants they have received, citing that they were told by "high-ranking officals" not to discriminate against their brothers and sisters. In addition to this, her response was:

> *Only the City of Joburg. I always see there is a migrant desk but when I enter to that place, I don't know if there is material or at that place. But here at our clinics we don't have.*
>
> (Mary, Administrator, Johannesburg, 22-01-2017).

Others in both sites stated that they did not have any knowledge of any policy, guidelines or training on how to treat migrants at all.

> ***KV**: Are you aware of any policy about how to treat migrants on ART?*
> ***Janet**: If the policy is there I haven't seen it [laughs]. If it's there, because you find us between them and the hard rock we don't know what to do. You refuse them treatment, then the next morning you are on the newspaper that you are refusing them treatment.*
> ***KV**: Are there any guidelines from DoH?*
> ***Janet**: No. Not of what I know. Dealing with the migrant the guideline that we have is things like from IOM. And we can't rely on IOM and other things. We need something from the government; how do we deal with them? But, we just deal with them like everyone, and sometimes dealing with them like everyone, ey (sighs), it doesn't suit them sometimes. Because they are on the way, some of them are truck drivers they are on the way. They just enter the clinic, "we need treatment, I'm on the way, I'm going to Zambia", or something like that.*
>
> (Janet, Nurse, Vhembe, 27-10-2016).

> ***KV**: Do you receive any training material on migrants, about treating migrants from the department?*
> ***Nancy**: Nothing, only from IOM. We have to come up with ways of adapting, and understanding of course the dynamics around migration.*
>
> (Nancy, Nurse, Vhembe, 31-10-2016).

> ***KV**: Do you receive any training material on migrants?*
> ***Moyo**: No. I didn't receive any training. No.*
> ***KV**: So you just do it yourself?*
> ***Moyo**: Yes.*
>
> (Moyo, Nurse, Vhembe, 29-10-2016).

> ***KV**: Do you have any training, materials or policy directives about treating migrants from the department of health?*
> ***John**: No. No. I think the issue here is when we go back to the constitution, there's no way where it says there should be some kind of or some sort of way of treating migrants. When you are within the borders of South Africa you are South African we treat you exactly the way we treat anybody else. There's nothing that is on paper that says you must treat anybody like this. […] Whether you are a local or a foreigner or a migrant, we treat you exactly the same way.*
>
> (John, Nurse, Johannesburg, 17-01-2017).

According to Janet and Nancy, non-state actors like the IOM played a crucial role in supporting health care workers to deal with cross-border migrant patients by providing resources like pamphlets and some guideline. Likewise, One nurse in Vhembe acknowledged the role of the Wits Health Reproductive Institute in providing trainings and materials. As Walt (1994) argues, policy actors include the government, the media, civil service, service providers, interest groups and international actors. But for Janet, this was not enough. She felt that the government still needed to provide such guidelines because she lacked faith in the material provided by IOM.

In order to brainstorm several policy ideas, the health care workers in Vhembe district municipality partnered with the IOM and Beitbridge District Ministry of Health in two collaborations; the Cross-border HIV/AIDS, STI and TB Technical Coordination Forum and the Migrant's Health Forum. Unlike Vhambe, in Johannesburg, the Johannesburg Migrant Health Forum remains largely attended and spearheaded by migrant NGOs and academic institutions.

4.4.2.1 Vhembe Cross-border Forum and Migrant's Health Forum

> *I don't think this whole bureaucracy is working for us. I think policy-makers need to be on the ground to solve things.*
>
> (Janet, Nurse, Vhembe, 27-10-2016).

In light of the above view, the Cross-border HIV/AIDS, STI and TB Technical Coordination Forum is a joint initiative between the Ministry of Health and Child Welfare in Beitbridge, Zimbabwe and The Department of Health in Musina, South

Africa. Responding to policy and coordination gaps, The forum was formed to facilitate continuity of care across the two districts and beyond, and to address the impact of migration and mobility on provision of health services. Through ongoing dialogue and action, it brings together various government departments, international organisations and civil society organisations mandated to deal with HIV/AIDS and TB, among other health issues affecting mobile populations and communities affected by migration (Founding document). The forum particularly responded to these forms of cross-border mobility:

i. Seasonal farm workers in the commercial farms along the Limpopo River making the bulk of movement between the two districts; and
ii. Many migrants (regular and irregular) frequently travelling back and forth between South Africa and Zimbabwe, seeking economic opportunities and health services.

The forum recognises the HIV risks that mobile populations are exposed to as they sometimes encounter thugs (*Magumaguma*) while crossing the Limpopo river or find themselves in precarious living and working conditions in hard-to-reach areas which may present challenges to accessing health care services and adherence. Some of the forum's objectives include:

i. Exploring innovative referral mechanisms to promote continuum of care for migrants and mobile populations (e.g. Health Passport; ehealth);
ii. Developing and implementing a tracking system across the two borders; and
iii. Creating platforms for learning and sharing experiences between the two districts.

The forum meetings are held once every two months, in Musina and Beitbridge on a rotational basis. In terms of policy issues, the forum abides by the policy and legislative frameworks of the two countries, and any matter related to policy implementation is referred to the provincial and national government levels of both countries. However, in essence, the forum can be read as a policy-making institution in and of itself. By sharing ideas and experiences, health care workers in Vhembe and Beitbridge were able to incorporate their own innovations into their daily needs of practice that were not addressed by any existing government health policy. I observed that the forum allowed health care workers to make informal input into policy where bureaucratic structures could not afford them to. This finding illustrates Vearey et al.'s (forthcoming) finding that local-level responses are the most successful examples

of approaches to address migration and health. For example, this was one health care worker's perspective on the forum:

> *We can make an input. Everyone can make an input, but it's a long way. From me to the sub-district what what, from the sub-district what what to the district, district to the province; if it happens to get there. But we can't say they are not doing, they are trying their best. Maybe with these forums of cross-borders, something will end up coming up.*
>
> (Janet, Nurse, Vhembe, 27-10-2016).

Another health care worker also acknowledged the role of the Cross-border and Migrant's Health Forum:

> *And of course the issue of the crossborder collaboration also assisting, and the issue of the migrant health forum also assisting. And of course the partner that is making us to sustain more is the International Organisation for Migration IOM.*
>
> (Nancy, Nurse, Vhembe, 31-10-2016).

The Cross-border forum and Migrant's Health forums resembled parrallel policy institutions. During my observation of these policy spaces, I could not help but notice how they were almost "informal parliaments", even in their decorum and approach. The meetings often began with an opening prayer and welcome note from the Chairperson, roll call and apologies by the Secretariat, adoption of minutes and discussion of the day's business. While informal, the conversations always adopted a formal and technical trope; with participants conducting themselves like diplomats, while ideas were presented and explored for possible uptake.

For example, in order to address current challenges related to continuity of care for ART patients, most health care workers felt that the department could do more to explore other options like the health passport. The issue of the health passport was a matter of great discussion at the forum meeting I attended. Even the health care workers I interviewed after the meeting had confidence in the potential of the health passport to support mobile patients. One health care worker stated:

> *I for one, I would go for the health passport other than the patient folder. Because with the issue of the patient folder, that's when they'll open the*

> *folder, this side and this side and that side and the other clinic and the other clinic. You find that one person has a hundred folders for the whole country. That is currently the system, but for the migrant I would propose the issue of the health passport. I'd advocate the health passport.*
>
> (Nancy, Nurse, Vhembe, 31-10-2016).

While there was a consensus that the health passport could help, some expressed doubt over the department's position on adopting parallel systems.

> *The Department of Health could do more but you heard with the issue of the health passport. That lady from IOM said they have like presented it to the DG and the DG has said you can't come with other programmes that are parallel. So it's like the government will only consider their people, with in case of the policies. I don't know.*
>
> (Janet, Nurse, Vhembe, 27-10-2016).

Therefore, it seemed that there was need to sell these systems to the national DoH. In spite of these differrences, there was political will from the District to ensure the success of the Forum and the innovations thereof.

These findings underscore several issues that abound in the literature on policy and the function of bureaucracies. The importance of informal elements such as human relationships, communication networks, leadership and motivation towards the policy function of any bureaucracy must be recognised (Bayo, 2013; Barnard, 1966). Organisations are not "impenetrable structures that implement policies, laws and regulations like conveyor belts of formal rationality" (Portillo and Rudes, 2014: 326). Bureaucracies do not always adhere to "formal hierarchy, written records, merit-based hiring, and standard operating procedures" (Portillo and Rudes, 2014: 322). Power is not necessarily a centralised force within the function of bureaucracies. Organisations are composed of members who like any other social actor, act differently, pursuant of their own interests, by maximising choices. It is not always that formal rules and procedures are observed. It is more likely that bureaucrats' agency "can constrain, facilitate, or transform formal organisational systems into complex congeries marked by informal cultures and shadow structures" (Portillo and Rudes, 2014: 322; Morrill, 2008).

4.5 Conclusion

Overall, identity documentation, referral letters, language and "blurrred" policies were identified by participants as a setback to their work, especially when dealing with cross-border migrants. In responding to this difficulty, there was a dual imperative in the form which the agency of health care workers took. First, health care workers seemed to have developed their own "social imagination" of cross-border migrant patients. Largely, these were negative perceptions which drew from mythology and not backed up by any concrete evidence. For example, undocumented migrants were perceived as taking lots of medication using different identities. In some responses to this effect, there was a "social imagination" that these migrants used ARVs for illicit purposes to make drugs like *nyaope* or *whoonga*. There was also an imagined perception of a "Human Tsunami"; an image in which cross-border migrants were perceived as coming to South Africa in their numbers just to access health care services. However, all these assumptions were weakened by the conflicting narratives between different respondents, who did not always agree on the actual reality of these perceptions. Furthermore, the vast literature presented in discussing these findings demystified most of these mythologies. Interestingly, the literature also illustrated that these negative perceptions must be understood a a strategic response to positions of dilemma and powerlessness experienced by these low-ranked frontline health care workers. This was backed up by the finding that the health care workers did not use their perceptions to rationalise the denial of care to cross-border migrants.

This takes us to the next finding which has been demonstrated at length; that health care workers adopted innovative practices to deal with various challenges. For example, the adoption of various lingua franca by health care workers in both sites, and the use of informal translators, illustrates this position. In both contexts, though under different pretexts, health care workers resorted to bureaucratic incorporation and including cross-border migrants into a localised form of (already problematised) therapeutic citizenship, which served both parties' interests. Innovation was also translated into informal policy streams and networks through forums that explored various ideas to harmonise and coordinate treatment between Zimbabwe and South

Africa. In sum, all these findings suggest that the health care workers in the clinics I studied were indeed frustrated by workload, understaffing and working hours, but they responded strategically in a manner that tried to facilitate access for all through a rights notion.

Chapter Five: Conclusions and Recommendations

This final chapter consolidates the key findings into academic and policy recommendations, conclusions; sets an agenda for future research and policy interventions. Already, the study has identified several findings which help address existing gaps in the literature on migration, health and policy-making in South Africa. By using a bottom-up theoretical approach to policy analysis, its contribution is the move it takes from a superficial conceptualisation of "medical xenophobia" to using Lipsky's concept of street-level bureaucracy as a tool to understand both negative and positive examples of health care workers' discretion when dealing with cross-border migrants in South Africa. Both forms of agency have been understood as coping mechanisms with a structurally inefficient workplace; as a way of responding strategically to an environment of staff shortages, long working hours and high workload, not merely xenophobic attitudes. While negative perceptions of non-nationals also exist among the health care workers included in this study, if anything, the study has found that these constructions of "problematic patients" – as per Moyo (2010) - have not been used to rationalise the outright denial of care. Rather, the study found incidents of bureaucratic incorporation and - to a certain extent - indications of possible therapeutic citizenship in Vhembe and Johannesburg respectively, which created other forms of transnational citizenship. Further research is however needed to further explore this.

Overall, the study had three main objectives. First, it was interested in understanding the practices that frontline health care workers adopted to navigate a space of "blurred policy and the "grey areas in-between. In meeting this objective, it found that health care workers were adopting positive discretion, through innovation and ad libbing. Frontline health care workers in the two sites vacillated from using dates of birth to registering undocumented migrant patients, filling up containers for those without referral letters to get by until they returned to their initiating facilities, improvising linguistic challenges through lingua franca and informal translators, and participating proactively in policy engagements through Health Forums.

However, these practices varied markedly across the two sites, which allows a discussion of how the study was able to meet objective two: to compare the experiences of frontline health care workers across an urban and cross-border health setting. It appears that the lack of documentation was not a cause for outright denial of ART treatment in both sites. Frontline health care workers opined that they were sticking to South Africa's "health for all" commitment. Frontline health care workers in both sites seemed to deal with lack of referrals by reinitiating or filling up containers for non-national patients who had them. However, there were some differrences. Responses to language barriers were largely similar, but the politics of linguistic difference were not alike with Shona and Venda appearing more similar for workers in Vhembe, as Zulu and Ndebele in Johannesburg.

Regarding documentation, Johannesburg was also an exceptional case in that the clinic I conducted research in was divided on how it approached issues of documentation along departmental lines. As it turned out, the ANC department insisted that anyone accessing care present their valid documentation, or they would not be admitted. As one respondent insinuated, this could have been a result of local political decisions.

However, while the use of Health Forums was key, it was only in Vhembe that I engaged with respondents who were actually part of the Migrant Health Forums. In Johannesburg, the Migrant Health Forum took a different form, which was largely civil society advocacy and more recently, partnership with maHp. This is possibly best explained by the contexts, in which Vhembe is closer to the border and has to deal with Zimbabwean migrants who find it closer to access services there than in Beitbridge. It appeared to me that the lack of harmonisation and coordination was much of a concern there, and in light of pilots that were done by MSF before, health care workers were aware of the potential value of developing self-owned systems. Yet, in spite of these differences, each forum appeared to be working best for the context it exists in.

Lastly, the study was interested in understanding the perspectives and experiences of frontline health care workers, and infering the various meanings they attached to the lack of any official state policy that harmonises ART treatment for cross-border

migrants. This is where the negative perceptions of cross-border migrants, which seemed to draw either on a few experiences or pure anecdote, emerged strongly. Frontline health care workers had created social imaginations of non-nationals coming to South Africa just to access health care services and non-nationals as unreliable and untrustworthy by presenting multiple identities in order to collect lots of treatment for relatives back home or for *nyaope* / *whoonga*. Interestingly, these perceptions did not translate into the outright denial of care, but just suspicion.

The study's major limitation was that, in addressing the concern of methodological nationalism, it couldn't compare the responses of participants with the voices of cross-border migrants, which is where it makes a cautious claim to the idea of therapeutic citizenship. However, where there was no consensus, it still managed to make referrence to existing literature to confirm various claims.

Altogether, the study concludes that health care workers use their discretion to adapt strategically to dilemmas of blurred policy, poor, uncoordinated systems and limited resources (staff, linguistic etc.). In navigating the "grey areas in-between", they funtionally use their negative perceptions to blame non-nationals for their dilemma, when in fact the problem lies with the above mentioned structures. Yet, still, in all this, they strive their best to provide ART treatment for all.

Going forward, there is need for more mulitisited studies that engage with the agency of various street level bureaucrats that interact with cross-border migrants to understand the multi-dimensions of institutional xenophobia and what drives the stigmatisation of a certain group, in certain contexts. The public health care system is struggling and multiple forms of othering that take place need a grounded, contextual understanding. There is need for studies that will allow to explore these different forms of othering and how they are mediated by various contexts. It is also important to investigate further what drives local forms of innovation, beyond just policy loopholes.

There is also need for policy-makers to recognise the importance of informal elements such as human relationships, communication networks, leadership and motivation towards the policy function of the country's health system. Realising this, the

informal practices of frontline health care workers ought not only to be recognised but strenghtened where possible. Over and above all, there is need for a migration-aware regional and national public health approach that responds to the ART needs of cross-border migrants.

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Appendix

Appendix A – Interview guide

Interview Guide for frontline health care workers

Title of research project: Blurred policy and grey areas in-between: Exploring policy responses to migration and antiretroviral therapy treatment continuity in Johannesburg and Vhembe

Investigator: Mr. Kuda Vanyoro, MA Candidate, African Centre for Migration & Society, University of the Witwatersrand

Before interview starts:

1. Thank for interview and
2. Explain what I am hoping to do with the research
Looking at ART treatment continuity;
Focusing particularly on their experiences with providing ART treatment to internal and cross-border migrants without policy/guidelines;
3. Ask for consent and permission to record and then sign consent form and record

Talking points/Questions

Health worker profile and working conditions

1. Please tell me a little about yourself?
2. Where are you from?
3. How long have you been living here?
4. How long have you worked in this clinic?
5. What is your role at the clinic?
6. What does your daily work entail?
7. Where were you working before?
8. How do patients access your service?
9. What are their expectations from you?
10. Please explain the process that you go through when a patient approaches you to access treatment?
11. What are the challenges you face in providing quality care?

12. How are the working conditions in this clinic?

Perspective on migrants, migration and access to services

13. How do you understand the term ‘migrant’?

14. Do you consider yourself to be a migrant?

15. Do you get people who come here for a short time, just to access health services?

16. If yes, could you provide an average per month and where they come from (internal, cross-border)

17. Why do you think they come to this clinic?

18. Do migrants affect access to services for locals (ART, immunisation, TB)? *If yes, in what ways*

Policy, treatment protocols for migrant patients

19. How do you understand the term ‘policy’?

20. Have you received any training/materials/directive about migrants?

21. Are you aware of any protocols in place in this clinic about how to work with/treat migrant patients?

22. Are there any protocols in place in this clinic about how to work with/treat migrant patients?

23. What is your relationship like with the department of health?

24. Do you get consulted before any policy changes/amendments/introductions are made?

25. Do you think there are any shortcomings of the department of health’s approach to migrants accessing healthcare in this area?

26. Is there any further relevant information you think I might have missed in this interview?

27. Can you suggest any other individuals that I should talk to for the purposes of this study?

Ending off interview

1. Thank, and reiterate the use of the data collected during the interview.
2. Remind participant that they can call at any time to ask about the project, and they can withdraw their contribution at any time up until the Report is published (June 2017).

Appendix B – Participant observation information sheet

Participant Information Sheet for observing frontline health care workers

Title of research project: Blurred policy and grey areas in-between: Exploring policy responses to migration and antiretroviral therapy treatment continuity in Johannesburg and Vhembe

Principal Investigator: Mr Kuda Vanyoro, MA Candidate, African Centre for Migration & Society, University of the Witwatersrand

Dear Sir/Madam,

I will be conducting participant observation at your facility as a student at Wits University. I aim to collect information about your practices in health care service provision.

This information will be used to write a research report for my Masters studies. I therefore request your cooperation and assistance. I will write field notes during the observations. The observations are confidential and will be kept in a diary that will be stored in a lock secure locker and safely guarded at all times. Your identity will strictly be kept anonymous by use of pseudonyms. However, someone maybe able to identify you from the research report. The name of this facility will be blinded in order to address this risk.

You will not receive any direct benefit from participating in this study, other than assisting me in improving knowledge on the importance of policy in guiding health practices in the public health care sector.

There are no direct costs associated with this research project.

The field notes will be used in the writing of a research report. There are also possibilities that they will be reused for secondary data analysis.

If you have any questions about this research, please contact me at the ACMS. Tel: +27 (0)11 717 4680, on my mobile 0787699084 or email: kvanyoro@gmail.com
You can also get in touch with my supervisor Prof. Jo Vearey on +27 (0)72 392 7034 or email jovearey@gmail.com or the Wits Research Ethics Committee on +27 (0)11 717 1408

Thank you for your assistance,

Kuda Vanyoro (MA Candidate)
078 769 9084
kvanyoro@gmail com
The African Centre for Migration & Society (ACMS)
School of Social Sciences
Room 5, South West Engineering Building, East Campus
University of the Witwatersrand
P. O. Box 76, Wits 2050

Johannesburg
South Africa

Appendix C – Participant information sheet for interviews

Participant Information Sheet for frontline health care workers (Interviews)

Title of research project: Blurred policy and grey areas in-between: Exploring policy responses to migration and antiretroviral therapy treatment continuity in Johannesburg and Vhembe

Principal Investigator: Mr Kuda Vanyoro, MA Candidate, African Centre for Migration & Society, University of the Witwatersrand

Dear Sir/Madam,

I am inviting you to participate in an interview I'm coordinating as a student at Wits University. I aim to collect information about your experiences and perspectives regarding migration, health policy and access to antiretroviral therapy treatment in your clinic.

This information will be used to write a research report for my Masters studies. I therefore request your assistance in answering my interview questions. This interview will involve a series of questions about your work in the public health sector. You are also welcome to give me information about other individuals at the clinic that you think may be relevant to my study.

The interviews are confidential and will be stored in a password secure hard drive for protection. Your name will strictly be kept anonymous in reporting research results. I will try my best to ensure anonymity by the use of pseudonyms. However, someone maybe able to identify you from the research report. The name of this facility will be blinded in order to minimise this risk.

You will not receive any direct benefit from participating in this study, other than assisting me in improving knowledge on the importance of policy in guiding health practice in the public health care sector. It is your choice whether to be interviewed or not and here is no penalty for not participating. You can only answer the questions you want to answer.

There are no direct costs associated with this research project. It will, however take up to one hour of your time. I will be happy to conduct the interview in a place of your choice. I do not foresee any risks in your participating in the project as this project is solely for research purposes. With your permission, the interviews will be audio-recorded to ensure accuracy.

If you give consent to participate, your responses will be used in the writing of a research report. There are also possibilities that the interview data will be reused for secondary data analysis. You may withdraw from this project at any stage; this will not affect you in any way.

If you have any questions about this research, please contact me at the ACMS. Tel: +27 (0)11 717 4680, on my mobile 0787699084 or email: kvanyoro@gmail.com

You can also get in touch with my supervisor Prof. Jo Vearey on +27 (0)72 392 7034 or email jovearey@gmail.com or the Wits Research Ethics Committee on +27 (0)11 717 1408

Thank you for your assistance,

Kuda Vanyoro (MA Candidate)
078 769 9084
kvanyoro@gmail com
The African Centre for Migration & Society (ACMS)
School of Social Sciences
Room 5, South West Engineering Building, East Campus
University of the Witwatersrand
P. O. Box 76, Wits 2050
Johannesburg
South Africa

Appendix D – Consent form

Interview Consent Form

Title of research project: Blurred policy and grey areas in-between: Exploring policy responses to migration and antiretroviral therapy treatment continuity in Johannesburg and Vhembe

Principal Investigator: Mr Kuda Vanyoro, MA Candidate, African Centre for Migration and Society, University of the Witwatersrand

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Consent Form/Frontline health care workers

	Circle your response
I understand that I am under no obligation to take part in this project	**Yes / No**
I understand that I have the right to withdraw from this project at any stage	**Yes / No**
I understand that the interview is confidential but anonymity is not fully guaranteed	**Yes / No**
I have read/been read this consent form and the information it contains and had the opportunity to ask questions about them	**Yes / No**
The researcher has explained to me that the tapes will be transcribed (typed out) and used only for the purposes of this study	**Yes / No**
I agree to be interviewed for this research project	**Yes / No**
I agree to my responses being used for research and re-used for secondary data analysis	**Yes / No**
I give consent to be audio taped during the interviews	**Yes / No** **Signature:** _____

PARTICIPANT:		
_____	_____	_____
Printed Name	Signature of Participant	Date

Appendix E – Gauteng research permission

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

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JOHANNESBURG HEALTH DISTRICT

Enquiries: Dr EM Ohaju
Tel: +27(0) 11 694 3887
Cell: 082 731 6672 / 076 8831659
Email: Elizabeth.Ohaju@gauteng.gov.za

Hillbrow CHC: Administration Building
Cr Smith Str. & Klein Street
Private Bag X21, Johannesburg
South Africa, 2017

100 Jarrisen Street
Braamfontein

E-mail: kvanyoro@gmail.com

Date: 13/12/2016

Ref: 2016-17-060

Dear: Mr Kudakwashe Vanyoro

Re: 'EXPLORING *POLICY RESPONSES TO MIGRATION AND ART TREATMENT'*

Your application dated **2016/11/12** refers.

The District Research Committee has reviewed your application. This letter serves as an in-principle approval to access the Districts Health facilities (mentioned below) for the above project subject to following conditions:

The facility to be visited **:** Yeoville Clinic, Jourbert Park Clinic

- The research can only commence after you submit an ethics clearance certificate from a recognized institution.
- This facility will be visited from 15/12/2016 to 30/11/2017

Region	Regional Health Manager	Contact No.	Cell phone
ABEF	Mr Peter Mathole	011 440 1259	082 772 0582

- You will report to the Facility Manager before initiating the study.
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit a six-monthly progress report to the District Research Committee.
- Your supervisor and University of South Africa will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.

Appendix F – Limpopo research permission

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650) Ref:4/2/2

Vanyoro K
Human Research Ethics Committee

Greetings,

RE: Blurred policy and grey areas in-between : Exploring policy responses to migration and antiretroviral therapy treatment continuity in Johannesburg and Vhembe

The above matter refers.

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

Your cooperation will be highly appreciated.

Head of Department

06/10/2016
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

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Appendix G – Ethic clearance certificate

Research Office

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

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H16/07/38**
PROJECT TITLE	Blurred policy and grey areas in-between: Exploring policy responses to migration and antiretroviral therapy treatment continuity in Johannesburg and Vhembe
INVESTIGATOR(S)	Mr K Vanyoro
SCHOOL/DEPARTMENT	Social Science/
DATE CONSIDERED	22 July 2016
DECISION OF THE COMMITTEE	Approved unconditionally
EXPIRY DATE	25 August 2019

DATE 26 August 2016 **CHAIRPERSON** J-Knight
(Professor J Knight)

cc: Supervisor : Professor J Vearey

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

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

_____ _____/_____/_____
Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES