Exploring the governance of maternal health. The case of migrant women living in Jeppestown, Johannesburg South Africa.

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Contents

Declaration

I, MOFFAT R. MACHIWENYIKA do solemnly declare that this research report is my own original and unaided work. This research report and all of its contents has not been used as a submission for any other degree or submitted at any other university.

Moffat Machiwenyika

Johannesburg, 29 June 2018

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Abstract

The post-Apartheid South African government has made significant changes in terms of policies, including access to health through The National Health Act of 2003 in which people were to gain access to health care services in the public healthcare system regardless of nationality. The Act made ground breaking provisions that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities regardless of nationality and residence status (National Health Act; 2003). Despite these progressive clauses in legislative framework that upholds the right to access healthcare for all in South Africa, access to maternal health care for both internal and cross-border migrants remain a stressful challenge, particularly in public health care facilities. My study explores the governance of maternal health using the case of migrant women who often experience the difficulties of accessing health services in public health care institutions. Migration is a form of geographical or spatial mobility between one geographical area and another, and it can be categorised as permanent or temporary. The study identifies Jeppestown as the study site. Jeppestown is situated in the outskirts of the city of Johannesburg (Gauteng Province) in South Africa and it falls under Region F of the city of Johannesburg Metropolitan Municipality. Migrant percentage in Jeppestown (internal and cross-border) is estimated at 47% and to this Jeppestown is migrant dominated and most of them are poor and depend on public clinics and hospitals. Jeppestown is migrant populated city with internal migrants coming in from all the nine provinces of South Africa as well as cross-border migrants from Zimbabwe, DRC, Malawi, Mozambique, Tanzania and Kenya among others. The study targets health governance actors including frontline healthcare staff. Informed by the access to health care framework, the overall methodology employed is qualitative approach and research design is a case study. Drawing from the non-probability sampling technique, respondents were identified and selected purposively. Semi-structured interviews were used to source ideas from the selected actors and an interview schedule was the research tool. Thematic content analysis was employed to analyse the data. This study therefore serves the critical function of informing the scholarship and various stakeholders in the public healthcare institutions on issues related to maternal healthcare and problem of governance of maternal healthcare at facility and District level focusing on migrant women. It also serves to inform recommendations for improving the accessibility of maternal healthcare services to migrant women particularly in Jeppestown, Johannesburg South Africa and South Africa as a whole adding nuance to migration and health discussions showing the similarities and differences in types of migration and the need for health policy to engage more broadly with mobility.

Chapter One

1.0 Background and Statement of the Problem

The study sought to explore challenges in governance of health where women in general are constantly facing maternal health challenges. Maternal health as part of the reproductive health of migrant women might be compromised when they face exclusion and must negotiate for access to public healthcare (Makandwa & Vearey, 2017; Makandwa, 2014). WHO (2012:vi) define governance for health and well-being as, "the attempts of governments and other actors to steer communities, whole countries or even groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches". The study looks at issues in the governance of health with reference to maternal health at public health care facilities (clinics and hospitals) that influences migrant women in accessing public maternal health. IOM (2017) defines a migrant as, "*any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is*". The study will use the case of migrant women living in Jeppestown, Johannesburg South Africa.

Jeppestown is located in the outskirts of the city of Johannesburg (Gauteng Province) in South Africa and it falls under Region F of the city of Johannesburg Metropolitan Municipality. According to the Johannesburg Population Survey (2008;2011), migrant percentage in Jeppestown (internal and cross-border) is estimated at 47% which indicates that the area is a migrant town. The Survey reveals that Jeppestown is migrant populated city with cross-border migrants from Zimbabwe, DRC, Malawi, Nigeria and Kenya among others. According to the 2011 Census, Jeppestown had a total population of 14 795 with women representing 48.26% of the population. Most of the migrants who reside in the area are of low income and depend on public clinics and hospitals. This chapter discusses and highlights key issues of the study focusing on the governance of maternal health, public healthcare system of South Africa, migration and women in South Africa. Research question, objectives and rationale of the study will also be stated in this section which will lead to the literature review.

The access to public maternal health of migrant (internal and external) women is important but a neglected topic in migration studies. Exploring the lived realities of migrant women who are often vulnerable when they face exclusion, on issues to do with access to maternal health is especially pertinent given the continued high levels of maternal mortality in many African countries including South Africa (WHO,2014). Besides the proposed study's likely contribution in understanding women's

reproductive health in relation to the governance of maternal health, this study seeks to generate new knowledge about the maternal health of migrant women, a population which often faces challenges of marginalisation and exclusion from health care services in South Africa (Vearey, 2014). This will also allow the confrontation of access to health injustices (Morse, 1995) on women's needs looking at governance of public maternal health in South Africa focusing on Johannesburg.

Migration is at the best of times a very complex phenomenon to study, and at the same time it is currently one of the most hotly questioned themes in contemporary public debates and among scholars (Stats SA, 2011). Declining and disparate economic conditions, armed conflict and political unrest all have culminated in the migration of considerable millions of people in sub-Saharan Africa in the past decade (McCarthy et.al, 2009:2; UNHCR,2007). Southern Africa has an inextricably long history of circular labour migration, internal, and increasingly cross-border migration of heterogeneous migrant groups whose evidence can be traced back from the mid-nineteenth century (Crush et.al., 2005; Adepojou 2006; Lurie 2006; Landau and Wa Kabwe-Segatti, 2009). South Africa is believed to be the centre for migration, with 1,6 million people (approximately 3,4%) of the country's inhabitants being non-citizens cross border migrants (Vearey, 2014). The figure might be even higher due to incidents of undocumented migrants (CoRMSA,2009; Jacobsen and Landau, 2003; Vearey, 2014: 663; Banati,2007). It is also important to note that in South Africa, internal migration contributes a bigger number than cross-border migration (Vearey, 2011) and notably internal migrants account for nearly four times as many individuals as international migrants (Zimmerman & Hossain, 2011). South Africa has been a migrant-receiving country since it is the economic hub of Southern Africa. The country experiences high levels of mobility into and within its urban centres incorporating movements from both within and across its borders (Misago et. Al.2010; Vearey, 2012).

Literature shows that internally, migrants in South Africa tend to concentrate around the country's major cities and Johannesburg (Gauteng Province) being the number one migrant destination (StatsSA,2018;Landau,2005). According to Statistics South Africa mid-year population estimates (2018), most international migrants settle in Gauteng Province (47,5%). The Province is regarded as the economic hub of the country and it attracts international migrants as well as domestic migrants who come from rural provinces such as Eastern Cape, KwaZulu- Natal, and Limpopo. Some come from within cities, between cities and some from smaller towns in search of opportunities. Landau & Gindrey (2008) states that Gauteng is the centre of South Africa's trade and is responsible for 10% of sub-Saharan Africa's GDP. Gauteng consist of the largest share of the South African population with an estimate of 14,7million people (25,4%) living in this Province (StasSA,2018). 51% of the South African population is female which is approximately 29,5 million. This includes international female migrants residing in the country (StatsSA,2018).

Patterns of migrants within South Africa have ranged from seasonal migrants, labour migrants, informal migrants, sex workers and asylum seekers among others (Landau,2005;McCarthy et.al,2009). This led South Africa to be the Southern African Development Community (SADC) member state with highest rates of cross-border migration (StatsSA,2018; Vearey, 2010). It is however, important to note that internally the same can be said especially into Johannesburg from all the nine provinces of South Africa (Vearey, 2015, Stats SA,2016). It is crucial to highlight that these migration patterns need to be positioned in a proper historical context. Historically, most migrants were labour migrants within, and into South Africa, who were mainly men. These migrant men were not permitted to bring their spouses and families with them to their places of work (Posel, 2004). Wentzel & Tlabela (2004) posits that South Africa has had a sad history of racially based government interventions in the movement and settlement patterns of its own people and those from other countries in the region. This has caused grave effects on the well- being of most of its population.

The republic of South Africa since the end of apartheid has made significant changes in terms of policies and amongst these were changes regarding access to health. The National Health Act in which people can gain access to health care services in the public healthcare system clearly states that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities regardless of nationality and residence status (National Health Act; 2003). Despite these progressive changes in legislation that upholds the right to access healthcare for all in South Africa, both internal and cross-border migrants are said to be experiencing challenges in accessing public healthcare (Vearey, 2011). Migrants continue to be portrayed as diseased people who place burdens on the public healthcare system (Chopra et.al,2009). In South Africa, female migrants have been recognized as an important challenge for public health (Makandwa & Vearey, 2017; Vearey et. Al., 2015; Makandwa, 2014; Landau, 2015). MacPherson & Gushulak (2001) state that the relationship between migration and health is known to be complex. Migration is recognised as a central determinant of health, needful of appropriate policy and programme responses. Migration can defiantly affect the health of migrant women as they are likely to be of conceptive age and with specific health demands (Obuaku-Igwe, 2015).

Vearey (2014:663) states that, South Africa as a member state of SADC is one of the recipient of migrants from SADC and this region has an escalating level of migration with high communicable disease burden and struggling public health care systems. To this it is important to look at the governance of maternal health using the case of migrant women.

Section 27 of the South African Bill of Rights, for example, states that everyone (not just citizens) has the right to have access to healthcare services and that no one can be denied emergency medical

services (SA Constitution, 1996). Recently, migration and health have received new attention, and this is evident through the 2008 World Health Assembly (WHA) Resolution on the Health of Migrants which is under section 61.17 (WHA, 2008). The resolution calls upon all member states to ensure the health of migrant populations through a collection of actions vis-à-vis promoting migrant-sensitive health policies; promoting equitable access to health promotion, disease prevention and care for migrants amongst others (WHA 2008; Vearey, 2011:58). In May 2017, the Assembly met for its 70th World Health Assembly and one of the major agenda was for all member states to promote the health of migrants and refugees (WHA,2017;WHO,2017) To this, South Africa is not an exception and is obliged to adopt this. Moreso, the 2030 Agenda for Sustainable Development has explicitly recognised the needs of refugees, internally displaced persons and migrants. The Agenda perceives the positive contribution of refugees and migrants for inclusive growth and sustainable development for which good health is a prerequisite (WHA,2017;WHO,2017).

According to WHO (2015), the access to health issues of migrant populations are an important public health concern. This means that the health care needs of migrant women should be an area of great concern nationally and internationally giving special focus on issues of sexual and maternal health including access to maternity care and in most cases, they have worst maternal outcomes than native born women (Bollini et. Al., 2009) and South Africa is not an exception. Under the S.A constitution and the S.A National Health Act everyone has a right to healthcare including non-nationals/migrants (internal and external) but the reality is that they normally experience challenges in accessing public health (Vearey et. Al., 2016; Obuaku-Igwe, 2015, SA Constitution, National Health Act, 2003).

This research was therefore motivated by the need to explore the governance of maternal health using the case of migrant women. Focus will be to explore reactions, responses and getting an insight from the key health governance actors, including frontline healthcare staff basing on findings of previous research (Makandwa, 2014; Pophiwa, 2009; Walker, 2015; Adams, 2015; Makandwa & Vearey,2017) on the experiences of migrant women accessing maternal healthcare.

1.1 Research Question

The research is aimed at answering the following:

What are the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown?

1.1.1 Research Objectives

In order to answer the research questions, the following are the research objectives and the research instruments to be employed to achieve them:

Objective (s)	**Research Instrument**
1. To identify appropriate frameworks to guide the study.	Reviewing literature on governance of health.
2. To do a desktop review of research literature on migrant's maternal health issues in Johannesburg so far and governance of health focusing on the health system response.	Desktop review of Health policies and Acts in South Africa, literature on migrant's access to health, reports, thesis on migration and health.
3. To understand how governance actors conceptualise migration and health when formulating and implementing health policies.	Conduct in-depth interviews with governance actors, personnel (nurses), facility and regional managers and frontline staff at Jeppe street clinic.
4. To understand what are the local level factors influencing access to public maternal health of migrant women.	Conduct in-depth interviews with governance actors in the City of Johannesburg (Region F), facility managers, personnel (nurses) who are responsible for the development of healthcare responses.
5. To understand the experiences of internal migrant women in are accessing public maternal health and whether these experiences differ from those of cross border migrants	Conduct in-depth interviews with internal and external migrant women accessing maternal healthcare at Jeppe clinic.
6. Inform recommendations for improving the governance of maternal healthcare	

in order to improve access to health for migrant women.	

Above all, the study will serve the critical function of orienting the academia, various stakeholders and adding to the body of available literature on governance of maternal healthcare of migrant women.

1.2 Rationale

The rational of the study was motivated by the knowledge and fact that there is an accelerating rise in figures and diversity of migration across the globe. Matters pertaining to the experiences of accessing maternal health care by migrant women have been growing in significance in the academic field (Coovadia et. al., 2009). In relation to the increasing figures and changing trends in migration across the globe where feminization of migration is on the rise, issues regarding the provision and access to maternal health care of migrant women are highly pertinent (WHO,2016,Nour, 2008; Moyo, 2010; IOM, 2013; Human Rights Watch, 2011; Makandwa, 2014; Adams, 2014). Adams & Rother (2017) states that, given the stretched public health services, providing adequate access to health care services for all is a current challenge in South Africa. Migrant women often encounter challenges in accessing public maternal health. In South Africa, female migrants have been recognized as an important challenge for public health (Makandwa & Vearey, 2017; Vearey et. al., 2015; Makandwa, 2014; Landau, 2015). Worldwide maternal mortality is a significant risk amongst women and much needs to be done to improve maternal health. Risk for maternal death (during pregnancy) in sub-Saharan Africa (South Africa included) is believed to be 175 times higher than in developing countries. The risk for pregnancy-related illness and negative consequences after birth is even higher (World Bank; 2014). Improving maternal health was the 5th of the UN 8 MDGs targeting a reduction in the number of women dying during pregnancy and childbirth by ¾ by 2015 (UN, 2015).

WHO (2014) states that the rising number of maternal deaths in some areas of the world shows inequities in access to health services highlighting the gap between rich and poor. Almost all 99% maternal deaths occur in developing countries with more than half of these occurring in sub-Saharan Africa (WHO,2014). South Africa till today is still battling an uphill to reduce its maternal death rate after a spike in deaths during the height of the country's HIV pandemic. South Africa has cut maternal deaths from 189,5 for each 100 000 births in 2009 to 132,9 for every 100 000 of every 2012/13 (South African Health News Service,2013). Be that as it may, the country is still extremely distant from meeting the international commitment to cut maternal mortality to 38 deaths for every 100,000 births by 2015 as a feature of the worldwide Millennium Development Goals (MDGs). In Johannesburg maternal mortality rates are presumed to be escalating due to the influx of migrant women (internal and external) (SA Health News Service, 2013). Recently with the introduction of the SDGs, South Africa is still struggling to cut down on the Maternal Mortality Ratio (MMR). With the city of Johannesburg being a migrant dominated city with a high number of migrants being from within South Africa, this study sought to find out the health governance issues influencing access to public maternal healthcare services of migrant women using the case of Jeppestown.

Jeppestown is situated in the periphery of the city of Johannesburg in South Africa and it falls under Region F of the city of Johannesburg Metropolitan Municipality. Migrant percentage in Jeppestown (internal and cross-border) is estimated at 47%. Jeppestown is a highly migrant dominated area with many migrant women settling in the area and most of them are poor and depend on public clinics and hospitals (Johannesburg Population Survey, 2008, Census, 2011, StatsSA,2018). It has a total of 89,3% Black African population (JPS,2008). Jeppestown is migrant populated city with internal migrants coming in from all the nine provinces of South Africa as well as cross-border migrants from Zimbabwe, DRC, Malawi, Mozambique and Kenya among others. Initially it was just a light industrial area but in the past years migrants have been illegally settling in the area making it a residential town and most of the migrants reside in abandoned buildings.

Looking at the trends of migration, Vearey et.al. (2011) postulates that high levels of internal migration than cross-border migration is evident in South Africa. This is because people move from homeland to urban centres inorder to better their livelihoods. In this instance, recognizing the heterogeneous migration patterns occurring within South Africa looking also at internal migrant women and governance of maternal health will be a crucial aspect. It will allow for the development of migration-aware health responses that will seek to address the health of migrant women (Vearey, 2012). In this light, Peberdy, Crush & Msibi (2004:4) argue that, "as migrants, particularly internal migrants, constitute a relatively significant and sustained part of the population of Gauteng, and Johannesburg, any development policies for the city need to account for migrants and migration." Vearey & Nunez (2012:7) further states that as a country that is predominantly circular internal and cross border migration, it is crucial that South Africa develops, implements and monitors an evidence based, coordinated, multilevel national response to migration and health

Recently on its Seventieth General Assembly in 2015, the United Nations adopted the 17 Sustainable Development Goals (SDG) with 169 targets to be achieved over the next 15 years (WHO, 2015) and South Africa is a signatory to this. Goal 3 of the SDG is aimed at ensuring healthy lives and promoting well-being for all at all ages. From this, it should be questioned whether South Africa is meeting these targets and the fact that maternal health is identified as a development challenge. The maternal health targets include reducing child deaths by two thirds and universal access to reproductive health among others (UNFPA, 2015). Studies done such as that by Makandwa (2014) do not recognise local South African migrant women as migrants and there is a lack of understanding to who is a migrant. While the significant and enduring effects of experiences of migrant women in accessing public maternal health have been well-documented worldwide, it is quite surprising that little evidence exists about governance of maternal health using the case of migrant women. There is a lot of literature about experiences of migrant women at facility level (clinics, hospitals), there is also a lot of data about

health care providers' responses and women accessing care. However, little research has been done looking at the proper governance structures of health and how the data can be used to inform governance decisions of maternal health at the city example.

Report Layout

The report is structured into five chapters. The current chapter introduces the report. In the second chapter the report reviews the literature on migration and health, governance and governance of health. The same chapter discusses the theoretical and conceptual frameworks that will be used to interpret the findings of the research report. Chapter three describes the methodological approach that was used in the report. Following this section are findings and discussion of results. The report will finally conclude with summarising key findings and recommendations which sums up the whole report.

Chapter Two: Literature Review and Theoretical Framework

The following section will examine some of the literature that is important visa-a-vis the research question of this research project. It will also draw on literature that has a direct link with governance, migration studies (mobility) and health. The literature review will be based on themes which include: defining governance, governance of health, migration in South(ern) Africa, migration into Johannesburg, migration and urban health, migration and health, feminization of migration, and history and background of maternal health and health policies in South Africa. This will be followed by a focus on the frameworks which will be used to guide this study. The study adopted three frameworks: (1) Access to health framework popularly known as the health access triangle coined by Mclntyre, (2) the urban health framework, (3) the Governance of health framework. Therefore, it is my utmost intention that this review would help in determining what is known about migration, governance of maternal health of migrant women in Jeppestown, South Africa as well as help in establishing knowledge gaps in existing literature.

2.0 Defining Governance

Governance is defined as the establishment of policies, and continuous monitoring of their proper implementation, by the members of the governing body, it includes the mechanisms required to balance the powers of the members (with the associated accountability), and their primary duty of enhancing the prosperity and viability of the organization (Fukuyama; 2013, Muller; 2011). The WHO (2014:8) states that definitions of governance incorporate politics, policy, public administration, the association of these with civil society and private sector, and the impacts the different establishment have on socio-economic outcomes.

Siddiqi et.al. (2009:14) states that,

"Governance comprises the complex mechanisms, processes and institutions through which citizens and groups articulate their interests, mediate their differences and exercise their legal rights and obligations".

Dogson, Lee & Draker (2002:6) defines governance as, "the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals". Kooiman (1996:68) states that governance as a concept has been a catchword in the social science field such as political sciences, international relations, public administration and recently migration studies. On the other hand, McCarney (1996:4) defines governance as, "the relationship between civil society and the state, between rulers and the ruled, the government and the governed." Chotray & Stoker (2009) defines governance as the rules, whether formal or informal for collective action and decision making

in a system with diverse players and organisations. Defining what governance is can be very challenging since it has different perspectives that exist on what factors ought to be incorporated. Bekke, Kickert & Kooiman (1995) posit that the diversity of uses and the various definitions of governance presents a problematic situation in understanding governance. Some scholars criticize the concept as being too vague and there is often confusion over how best to conceptualise it (Schneider, 2004; Kohler-Koch & Rittberger, 2006:28). One may deduce that different definitions and applications of governance are more appropriate and useful under different circumstances. It should be noted however that the focus of my study was not on governance per se but the governance of the way that healthcare seekers (migrant women) experience in maternal healthcare i.e. governance of health in the context of migration at facility and District level. For this study, the above definitions of governance will be the working definitions as they align with governance of health.

2.1 Governance of Health

Literature around governance of health is essential for this study. Reviewed literature on governance of health turns a blind eye on migration. This is worrisome as migration should be considered as one of the crucial factor when looking at the governance of health. As stated earlier, it should be articulated that the focus of my thesis is not on governance of health or the Governance of Health Systems (GHS) but is on the governance of the way that healthcare seekers experience in accessing public maternal healthcare at facility and District level. There is a growing literature on governance and its impact on health (Burris et.al.,2007). The literature on health system governance reflects the broader governance literature. The WHO (2014) states that governance in the health sector refers to an extensive variety of steering and rule-making associated functions carried out by governments or decision makers as they try to accomplish national health policy objectives that are obliging to universal health.

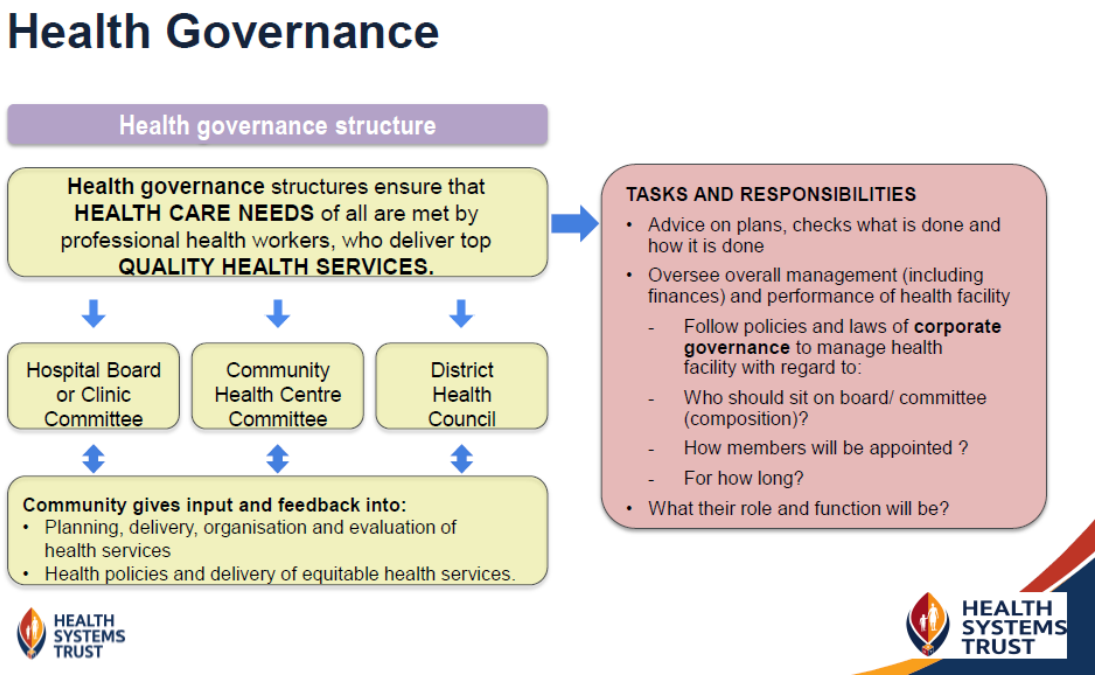
The WHO (2014:9) citing USAID (2013), further laments that the governance of health is “governance undertaken with the objective to protect and promote the health of the people”. Governance involves three aspects: setting direction and objectives; making policies, laws, regulations or decisions, and raising and deploying resources to accomplish the strategic goals and objectives; and overseeing and making sure that the strategic goals and objectives are accomplished (WHO:2014). Governance of the health system is the least well-understood aspect of health systems (Siddiqi et. Al., 2009). Dogson, Lee & Draker (2002:6), posits that “health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population.” They further state that health governance has been at the national and subnational level as governments of individual countries have presumed primary responsibility for the health of their domestic

populations. Historically, health governance can be drawn back to the ancient human societies where agreed rules and practices about hygiene and disease were implemented (Dogson, Lee & Draker 2002). The path to good governance in health is lengthy and patchy (Siddiqi et. Al, 2009).

The WHO (2014) outlined a plan of action for world health systems and governance that stipulates that moving closer towards governance of health requires: i) needed health services to be available, ii) of good quality and iii) affordable which in turn requires attention to all the various components of a health system including infrastructure, medicines and medical products, health workers, health information and health systems financing. According to WHO (2012:vi), WHO define governance for health and well-being as, "the attempts of governments and other actors to steer communities, whole countries or even groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches".

The WHO Regional Director for Europe, Zsuzsanna Jakab states that:

"Mind-sets for viewing and addressing health and its determinants have shifted. Two challenges go hand in hand: (1) the governance of the health system and the strengthening of health systems, which is called health governance; and (2) the joint action of health and non-health sectors, of the public and private sectors and of citizens for a common interest in what is called governance for health" (Kickbusch & Gleicher,2012:vi).



Extracted from: Gray A, Vawda Y, Jack C. Health Policy and Legislation. In: Padarath A, English R, editors. South African Health Review 2011. Durban: Health Systems Trust; 2011.

South Africa, like many other countries have ratified this, especially towards achieving the Millennium Development Goals (MDGs) till 2015 and now towards the Sustainable Development Goals (SDGs) till 2030. In South Africa, important changes have occurred in the health provision, leading to the increase in life expectancy to over 60 years for both male and female, historical injustices have been improved, access to healthcare has increased for the previously disadvantaged (Mayosi et. Al., 2012). The changes in the ministry of health have been instrumental in the reorganization of the healthcare provision. However, the efficiency has been inhibited by the stasis within the health management bureaucracy. There has been a cemented focus on the so-called colliding epidemics, HIV & tuberculosis, chronic illness and mental health, injury and violence, and maternal-neonatal-child health. HIV prevention has received increased attention, even maternal, neonatal and child health has improved (Mayosi et. Al., 2012). However, many risks factors for non-communicable diseases have increased. The ambitious government policies to address lifestyle changes such as decreased consumption of salt and alcohol show great promise. A system of national health insurance that seeks to re-engineer the primary healthcare and health insurance will be phased in by 2025 to enable universal access to healthcare (Mayosi et. Al., 2012).

The social determinants have remained largely discriminatory, [racial disparities and inequity between sexes, medical xenophobia], even though provisions have been made (Coovadia et. Al., 2009; Chopra et. Al., 2009). The treatment of migrants has remained suspicious and the health system seems to follow similar patterns. The provision of healthcare to migrants, particularly the disadvantaged, refugees and asylum seekers, has remained xenophobic, especially at facility level. This, like many other challenges of implementation in the health delivery system enables the criticism of the health system (Rispel, De Jager and Fonn, 2015). In recent times, the health system has faced three major crises, the Esidimeni crisis, where mentally challenged patients were moved from one place to another, and in the process about 91 of them passed away under unclear circumstances, the Cancer crisis in KZN where patients could not access the services and recently the National Health Laboratory Services (NHLS) crisis where the laboratory staff demands were ignored leading to industrial action, that jeopardized the blood tests for local patients in government facilities (Mail & Guardian,2017). These examples are not exhaustive. However, the general narrative is that the health provision is plagued by corruption, infective management and an unrepentant healthcare staff. Recently, scholars have put much attention and focus on “weak governance and the negative effects of corruption on the provision of health services” (Rispel, de Jager and Fonn, 2015:1) in the South African health sector.

The challenges in implementation have raised question about the willingness of government to engage with the public, to account for the healthcare provision. A case in point, the denialism of former president Thabo Mbeki that HIV was not associated with AIDS delayed the provision of the

needed treatment for the concerned patients. The lack of action of the Health MEC to deal with the Esidimeni Crisis, led to the death of patient that could otherwise have lived, and so is the KZN cancer crisis. Scholars (Mayosi et. Al., 2012; Rispel, De Jager and Fonn, 2015; Coovadia et. Al.; 2009) have argued on the one hand that the bureaucratization of the health care system allows for corrupt, ineffective and mediocre services. All these scenarios draw back to the issue at hand i.e. governance of health and one cannot turn a blind eye. Despite the incremental changes in the healthcare provision system, the shortfalls leave a lot to be desired. A major and worrying drawback is that the literature on the health governance does not include migration, yet migration is a topical issue and should be included in health governance.

2.1.1 Migration in South(ern) Africa

Literature around migration in South(ern) Africa is important for this study. Wilson (1976) states that migration in response to political and economic pressures is no new thing in Southern Africa. In support of this, the history of migration in Southern Africa has been identified as being "one of the most researched and well documented academic fields in the region" (Crush, 2000: 13). Southern Africa has an inextricably long history of circular labour migration, internal, and, growingly cross-border migration of heterogeneous migrant groups whose evidence can be traced back from the mid-nineteenth century (Crush et.al., 2005; Adepojou 2006; Lurie 2006; Landau and Wa Kabwe-Segatti, 2009). Migration was probably the single most important factor tying together all of the various colonies and countries of the sub-continent into a single regional labour market during the twentieth century (Crush, 2005:1).The numbers of people legally crossing borders throughout the Southern African region has exploded in the last decade. An example is that of South Africa where the annual number of visitors from other SADC countries has increased from around 1 million in the early 1990s to over 5 million at the present time (Crush, 2011). Looking at contemporary migration, Crush (2005:6) argues that states of Southern Africa can be divided into migrant-sending (Mozambique, Malawi, Lesotho) and migrant-receiving states (South Africa, Namibia) few, such as Botswana and Swaziland, fall into both categories. In South Africa alone, which is believed to be the centre for migration, 1,6 million people (approximately 3,4%) of the country's inhabitants are non-citizens cross border migrants (Jacobsen and Landau, 2003; Vearey, 2014: 663; Banati,2007).

Wilson (1976:452), states that in the context of Southern Africa the term migrant tends to be defined as meaning, "a worker who wavers between his home and his place of work over a distance which is greater than can be travelled on a daily commuting basis". He further states that Southern African countries such as South Africa, Southern Rhodesia (Zimbabwe) and Zambia has, over the years, experienced a more permanent migration of foreign-born Africans moving in and settling. Looking at

Southern Rhodesia, there is evidence that the first formal arrangements for migrant workers dates back to 1903 when the Rhodesian Native Labor Bureau was set up to coordinate recruiting of foreign labor for mines and plantations (Wilson,1976). Crush et. Al., (2005) postulates that the discovery of gold on the Witwatersrand changed the entire pattern of labour migration in the sub-continent. Initially most migrants came independently with male labour migration to the mines (South Africa, Zambia, Zimbabwe) and commercial farms and plantations (South Africa, Zimbabwe, Swaziland) being the most enduring form of legal cross-border labour migration within the region (Crush et.al.,2005).

Posel (2007) argues that during the 1990s, the focus of migration research in Southern Africa moved away from questions about labour migration to questions about immigration and permanent migration. Much of the recent research on migration in Southern Africa interrogates the negative stereotypes of immigrants and undertakes a critical review of South Africa's immigration policy from the perspective both of human rights and of regional development (Crush, 2005,2011; Posel, 2004; Landau and Wa Kabwe-Segatti, 2009).

2.1.2 Migration into Johannesburg

Within the South African context, circular migration of labour has dominated the country's migration history. Landau (2005) states that internal migrants tend to concentrate around the country's major cities with Johannesburg being a top migrant destination. According to Ahmad et. Al. (2010:5), "*The City of Johannesburg is one of South Africa's six Metropolitan Municipalities. It remains the prime economic hub of sub-Saharan Africa and the destination of choice for both skilled and unskilled migrant workers from beyond the provincial borders of Gauteng and national frontiers*". New migrants arrive daily making it one of the fastest growing megacities in the world. In just over 120 years, the city has grown to form what is now the economic hub of Sub-Saharan Africa (Vearey, 2010). Recent surveys discovered that Johannesburg has an estimated population of 4,4 million whilst the greater Metropolitan area has a population estimated at 8 million, unofficially (Johannesburg Population Survey, 2016). According to the survey, if the metropolitan area is defined loosely to include areas such as West rand and Lenasia then the population is about 10,5 million.

"Out of 4,4 million Johannesburg inhabitants almost 8% moved into the city from other provinces within South Africa" (CoJ, 2011:14). Vearey et.al., (2010) posits that internal and cross-border migrants who move to Gauteng migrant dense city tend to reside within the peripheral areas of the city. The movement is noteworthy, making Johannesburg an important "laboratory" for observing how the dynamics of human mobility affect processes of health, access and urbanisation amongst others (Kihato 2009:21). As Gauteng Province particularly became the economic heart-beat of the country, more and more people were lured to the province (particularly Johannesburg) in search of

employment opportunities, education and health among others (GEGDS:2014). Cross border migration patterns increased during the 1990s and even more so after the fall of the Apartheid regime that had placed ruthless migration restrictions on people based on their race and nationality (Crush et. Al.; 2005; Vearey et al.,2010). South Africa is destination for 58.4% of SADC migrants (IOM, 2016).

Migration into Johannesburg can be traced back to the 1880s. After the discovery of the Witwatersrand gold reef in 1886, the city of Johannesburg became, within a very short period of time, the financial and commercial hub of sub-Saharan Africa. A lot of migrant (internal and cross-border) workers flocked into the city to work in the mines (Bremner,2000:185). This implies that during this time labour migration was on the rise. According to Vearey (2017:1), Johannesburg or eGoli, "the city of Gold" is a city built on migration and mining but its association with gold, wealth, and prosperity was, and still is for the majority of its residents misplaced. Ahmad et.al. (2010:5) posit that it is a city of stark contrasts and it hosts extremes of poverty and wealth; straggling low-density suburbia and high-density formal and informal settlement; formal and informal trade. In contrast to most international cities, it is a 'young' city of just over a century in age. Kihato (2009:22) goes further to note that, with an administration and state infrastructure that is second to none in the region, Johannesburg provides a stimulating site to study how migration shapes and is shaped by a variety of urban relationships and reconfigures state power.

According to Crush (2005:13), the city of Johannesburg represents a "city of migrants." He further states that the city is a cosmopolitan centre that is a home to a heterogeneous population of migrants many of which are internal migrants. These internal migrants, most of which are believed to settle and reside in what Vearey (2010:37) calls "hidden spaces" in the inner-city areas and these are detached from the local government initiatives. The issue of migration into Johannesburg raises issues around the nature and character of cities, particularly how it shapes forms of belonging and dislocation, inclusion and exclusion in urban spaces (Kihato 2009). The city of Johannesburg is "a space of flows" which is also characterised by various structural obstacles and thresholds which limit migrant women's social, spatial and economic mobility (Vearey 2010:21) and access to services. Landau (2005) is of the similar view as he states that inside the South African urban zones especially in Johannesburg there is the conspicuousness of the nativist talk situated towards those from neighbouring nations by both the inhabitants and government authorities, asserting Johannesburg to be for citizens and othering non-nationals. This simply implies that migrants both internal and external migrants living in Johannesburg are seen as economic and physical threats. Even when they seek services such as public health they are usually denied access and in the long run this has immediate and long-term consequences (Landau 2005). He further laments that universal assumptions of non-nationals' criminality and threats to jobs and health have created a series of extra-legal and, often unconstitutional, practices oriented towards

their control and eventual removal. Politicians and civil servants in both countries have also taken the same stance on the presence of foreigners and international agencies to promote their own interests and elude blame for their own failings (Landau 2005:1120).

Landau's discourse carries weight looking at the South African context, migrants and migration into Johannesburg. Cases include the issue of non-South Africans being denied access to HIV treatment and that they should pay for their anti-retroviral treatment (SABC News, 2014, Daily Maverick,2014), the health minister publicly saying that South Africa's healthcare system is strained by refugees and migrants (The Citizen,2017) and the Johannesburg mayor, Herman Mashaba resonating Donald Trump that the South African government should shut down the South African border due to the influx of undocumented immigrants flocking into the country (Mail & Guardian,2017).

The South African cases creates and reinforces migrants as not belonging (Grove and Zwi,2006). These exclusionary tendencies are at variance with the aspirations of the migrants in pursuit of livelihoods by being excluded from the polity and health delivery system of the receiving country thus keeping them in obscurity (Agambeni,1998). This is further supported by Groove and Zwi (2006) in their "othering theory" which explains how migrants are received in developed countries and its implications on public health. They further lament that it identifies a variety of mechanisms by which refugees, asylum seekers; irregular migrants and migrants in general are positioned as the 'other` and are defined and treated as separate, distant and disconnected from the host community. This a dreadful contravention of the World Health Assembly resolutions (2008) which clearly advocates for an adoption of a 'migrant aware' health policies which guarantees universal access of healthcare by all to ensure equity in the distribution of healthcare services. Vearey (2017:2) citing (Balbo and Marconi 2005:13) states that large numbers of Johannesburg's populaces live with "weak rights to the city"; poor, urban, non-migrant, and migrant groups (both internal and cross-border) face challenges in realising their rights to access public healthcare, social services, employment, and secure tenure. To this, this literature will be relevant as it seeks to explore the governance of maternal health using the case of migrant women living in Jeppestown, Johannesburg.

2.1.3 Migration and Urban Health

Migration and urbanisation are concepts surrounded by great deal of controversy. Urbanisation has come with a lot of dynamics and the issues of health is topical when it comes to urbanisation. Garenne (2006) states that urbanisation is linked with a high frequency of migration to urban hubs which includes rural-to-urban economic migration, circular labour migration, and movement across borders by those seeking asylum. Urban health concerns itself with the determinants of health and disease in

urban areas and with the urban context itself as the exposure of interest (Galea, Vlahov; 2005:342). According to Galea and Vlahov (2005:343), factors affecting health in the cities can be considered in three themes namely the physical environment, the social environment, and access to health and social services. Most researchers both in the popular press and in the academic literature, have long been interested in cities and how they may affect the public's health (Vearey, 2010, 2005, Obuaku-Igwe, 2015). Estimates states that 50% of the world's population are living in urban areas and by 2050 it is estimated that the figure will be 70% of the world's population living in towns and cities (UN DESA, 2015).

Dye (2008) posits that the majority of people now live in urban area and even those who migrate internally or externally settle in mainly in urban areas and will do so for the foreseeable future. Vearey (2011:2) further postulates that this process of urban growth is accompanied by in-migration from within the country (internal migration) and across borders (cross-border migration). The result is that as a force in the demographic transition, urbanisation is associated with high birth and death rates. She further suggests that the main obstacles to improving urban health and access to health are neither technical nor financial but are rather related to governance and the organisation of the civil society. Urbanization has caused serious health patterns escalating health inequities and affecting sustainability in housing, infrastructure, basic services, food security, education, employment, safety, and natural resources, among others (Obakwu-Igwe,2015). As cities become more established, an aging infrastructure can threaten health. Growing inequalities and social strains can influence both health behaviors and access to resources. In addition, the course of urbanization in different cities worldwide may have different implications for health (Vlahov, 2005). Most research into the role of urbanization in shaping health focuses on how population change in cities, resulting from migration and population growth, may influence the distribution of diseases (Vlahov, Galea;2005).

Ompad et. Al. (2007) argues that the social environment is the most important theme to understanding the way in which cities affect the health of populations. Social determinants of health (SDH) are important, generally, yet can have different effects in different settings from urban to rural, between countries, between cities, and within cities. Failure to acknowledge, and more importantly, to understand the role of SDH in health and access to health and social services will hamper any effort to improve the health of the population (Ompad et.al., 2007; Obaku-Igwe,2015; Adams,2015). The social environment has been broadly defined to include "...occupational structure, labor markets, social and economic processes, wealth, social, human, and health services, power relations, government, race relations, social inequality, cultural practices, the arts, religious institutions and practices, and beliefs about place and community" (Barnet and Casper, 2001: 40). Individual social

experiences also may be important determinants of health in cities. For example, limited social support may predispose persons to poorer coping and adverse health.

Looking at urban South Africa, Vearey (2009:361) states that while South Africa has a shielding, integrative, urban refugee policy, many of these characters struggle to access the rights to which they are entitled, including healthcare and their stay in the city becomes unbearable. She further states that:

"*As a result, international migrants often become part of the group of 'urban poor,' falling within the periphery of health and social welfare provision and relying on a survivalist livelihood within the informal economy*" (p.g.361). This leads to the majority of the city population failing to access the positive social determinants of urban health and, as a result, faces an urban health penalty (Freudenberg et al. 2005; Vearey 2017). Provincial and local governments must therefore design and implement health policies that protect the urban poor who often experience a range of deprivations.

2.1.4 Feminization of Migration

Literature around female migration and its impact on service provision particularly health will be central in this study. Migration of women independent of men is often called feminization of migration (Gouws; 2007). This gender reconfiguration of migration started in the 1980s and is now unprecedented in scale, scope and complexity (Ulicki and Crush; 2007). In Sub-Saharan Africa women have been migrating since 1960 when female migration was 42.2% and women's migration was linked to the migration of men (Gouws, 2007). Men were seen to be the only main heroes of international mobility while women were seen as either deserted or latently following their spouses (Vause and Soma, 2015). Now women migrate autonomously and in 2005 the percentage of women migrating in 2005 was estimated at 47.4% of worldwide migrants (Paiewonsky, 2007). Migration of women especially in Africa is part of the survival strategies in response to the increasing poverty in the African region. According to a study by the International Labour Organisation (2015) a growing number of women are crossing borders in their autonomous capacity and looking for jobs, making 37% of more than 150 million migrant workers in the world. From the 1980s, research increasingly brought women to the forefront of attention and claimed to observe a rising global trend towards a feminization of migration flows (Castles and Miller, 1998; Piper, 2005). According to Boyd and Grieco, (2003); Morokvasic, (2008), while women's international migration is not a new phenomenon, women have long been absent from research in this area.

Recent scholars have however nuanced claims of feminization of migration arguing that the feminization of migration is neither a new nor a universal trend. A relative increase in the share of

women crossing borders is not necessarily convoyed by a complete increase in their numbers, which nuances the insinuations of the term "feminization" (Donato et al., 2006, 2011; Gabaccia, 1996; Piya and Donato, 2013; Schrover, 2013). Some argue that the term "feminization" of migration is not clear while most studies refer to a gradual increase in the percentage of female migrants (Alexander and Steidl, 2012; Boyd, 2006; Castles and Miller, 1998). Others point to an increase in absolute levels of female mobility (UNFPA, 2006), while yet others to an increase in women's economic mobility in particular (Piper, 2005; Verschuur, 2013). It is not always clear in the literature what the phenomenon of feminization actually describes and therefore how it should be measured. Most researchers and policy reports feminization of migration as an increase in the share of women in the migration stream and in this way measure changes in sexual orientation ratios among foreign-born populations. Alexander and Steidl (2012:224) take this idea a bit further when they state that the feminization of migration is a dynamic process in which "international migrant streams formerly dominated by men gradually become gender-balanced or even majority-female".

In South Africa, during apartheid women bore the brunt of the restrictive apartheid laws as they were unable to join their spouses in the cities, or migrate on their own and had to subsist on ever declining agricultural land in overcrowded rural Bantustans (Pick and Cooper, 1997; Wentzel and Tlabela, 2004). The end of apartheid, a system designed to control movement and exclude outsiders, produced new opportunities for internal and cross-border women's mobility and new incentives for moving. Salih (2011) is of the view that the types and patterns of women's migration currently are extremely heterogenous. Women now migrate under different scenarios, some under family reunion schemes, as single migrants, to pursue their studies, for health purposes, or as active agents of trade and as economic migrants.

2.1.4 Migration and Health

Literature on the historical patterns of mobility and migration has been constantly increasing and it postulates that there is need to connect migration and health (Vearey and Nunez 2010; MacPherson and Gushulak, 2001; Banati, 2007; Vearey, 2014). Investigation of migration and health frequently compels us to recognize that the types of migration (international and internal) interact with each other as well as other population parameters such as age, sex, fertility, mortality and family structure amongst others (Evans 1987:v). Crush et.al. (2005b) argues that paramount to understanding migration and health is the need to identify social complex challenges of different migrant groups within spaces of vulnerability that is associated with migration. Several scholars and researchers have been on the forefront of advocating for healthy migration in the African region. They have highlighted strong linkages between contemporary migration and spaces of vulnerability which expose migrants

to risky behaviours (Vearey, 2011a; Banati, 2007; Vearey et.al.,2010). MacPherson and Gushulak (2001) brings to light that linkages between migration and health are not linear. Important to understanding health and migration is the need to identify social complex challenges of different migrant groups within spaces of vulnerability as well as including internal migration and cross-border migration which is mostly ignored in health planning and governance. Looking at South Africa, Vearey (2010:6) argues that current health-system planning within South Africa does not effectively engage with the health of migrants when they are in urban and peri-urban areas and the end result is that migrants often migrate back home to their rural areas in the event that they become sick. According to WHO (2010), cited in Zimmerman & Hossain (2011:1),

"*Health policy-making in the context of migration has generally been viewed either in terms of its ''threats'' to public health or from a rights-based approach that focuses on health hazards faced by individual migrants and the associated service challenges*." Historically, the majority of the health matters linked with migration, or taking place as a result of migration, have been managed at the national level. This has been accomplished through either immigration health activities or exclusion, or as a factor of other local health programs (Gushulak, Weekers and MacPherson,2009; Zimmerman & Hossain,2011; Gushulak & MacPherson,2060). Attention to the health of migrants in South Africa is still restricted and where migration health policies do exist they function primarily in isolation (Zimmerman & Hossain, 2011:5). Vearey & Nunez (2008) citing Harper & Raman (2008:18) state that the isolation of non-citizen groups has resulted to health becoming conflated "with the politics of citizenship" and in many instances leading to denial of healthcare to non-citizens.

Various negative assumptions have been brought forward which unjustifiably relate cross-border migration and internal migration with the spread of diseases and healthcare seeking. This in the long run positions migrants as placing a burden on the healthcare system of host countries (Vearey, 2010:7; Harper & Raman,2008). The migrant body has always been associated with disease in both the public mind and academic literature (Boyle & Norman,2009). Zimmerman & Hossain (2011:1) argue that, "although often framed as a ''threat'', human mobility is not inherently risk laden". The relationship between migration and health is a complex one.

Migration is recognised as a central determinant of health calling for appropriate programmes and policy responses (Vearey 2011). According to Davies, Basten & Frattini (2009:v), migration can itself be seen as a determinant of migrants' health. They further state that migrants are highly prone to experience challenges in relation to health due to the nature of being a migrant. These challenges eventually affect their health especially in settings where they confront a mix of social, legal, economic and communications barriers. Roux & van Tonder (2006:121) further state that when looking at issues

that relates to migrant health there are variables to be considered. These include physical health, functional health, psychological health, health-seeking behaviour, and the accessibility and inaccessibility of health care. According to Lurie & Williams (2014), quoting Carballo, Divino, & Zeric, 1998; Quinn, 1994, migration has become one of the most important determinants of global health and social development.

2.1.5 History and Background of Maternal Health & Health Policies in South Africa

According to Coovadia et.al. (2009:817),

"*The roots of a dysfunctional health system and the collision of the epidemics of communicable and non-communicable diseases in South Africa can be found in policies from periods of the country's history, from colonial subjugation, apartheid dispossession, to the post-apartheid period".* They additionally express that different factors, for example, racial and sex segregation, migrant labour system and huge pay disparities have all framed piece of South Africa's harried past, and all have relentlessly affected health and health services. The South African health system since the end of Apartheid in 1994 has confronted gigantic difficulties a large number of which still persist. Significant features of primary health care are not in place and there is a substantial human resources crisis confronting the health sector (Vearey et.al,2010, Coovadia et.al,2009). Various scholars have noted with great concern that the South African history has had a distinct outcome on the health of its people and the health policy and services of the present day South Africa (Vearey et.al, 2010; Coovadia et.al.,2009; Chopra et.al.,2009). Bradshaw et.al., (2000) also posit that in South Africa, illnesses related to poverty such as maternal death and malnutrition remains prevalent and there is a high burden of non-communicable diseases.

It should be noted that the South African Constitution holds the state accountable to work towards the progressive realisation of the right to health. Yet 24 years after democracy the country is still battling with massive health inequities and the challenges of transforming institutions and promoting equity in development (Coovadia et.al,2009). Although South Africa is viewed as a middle-income country regarding its economy, it has health results that are far more worse than those in numerous lower income countries (Vearey,2009; Coovadia,2009). There has been insufficient political will and initiative to oversee underperformance in the public society. There has likewise been a headstrong inclination to retain incompetent ranking staff and pioneers, including (up to this point) the previous Minister of Health (Coovadia et. Al.,2009:830). "*Incompetence within the public sector is so*

widespread that it is an issue that has become very difficult to deal with. Limited capacity is a problem at every level of the health sector and throughout other sectors of government" (pg. 831).

Coming back to the history and background of maternal health in South Africa, Cooper et.al.,(2009:70) states that before 1994, there were no comprehensive reproductive health policies in South Africa. With regards to global patterns, women's health services comprised mainly of maternal and child health with emphasis on contraceptive services directed at restricting population growth (Koblinsky, Campbell & Harlow,1993). Maternal health administrations were described by overcrowding, understaffing and lack of privacy furthermore, women encountered access problems (Rees,1994). The public-sector health system was divided and described by geological and racial imbalances. The best proportion of health resources were channelled to the white minorities in urban areas (Cooper et.al.,2009). According to WHO (2012), due to the HIV epidemic and underperformance of the health system, South Africa was one of only a dozen countries worldwide with increased mortality since 1990 for MDGs 4 (child survival) and 5 (maternal health).

Maternal mortality statistics before and after 1994 cannot be authentically compared. Prior to 1994, data were typically collected only in urban areas and among women giving birth in maternity homes. This led to substantial underestimates of maternal mortality. South Africa has cut maternal deaths from 189,5 for each 100 000 births in 2009 to 132,9 for every 100 000 of every 2012/13 (SA Health News Service, 2013). Be that as it may, the country is still extremely distant from meeting the international commitment to cut maternal mortality to 38 deaths for every 100,000 births by 2015 as a feature of the worldwide Millennium Development Goals (MDGs). Recently with the introduction of the SDGs, South Africa is still struggling to cut down on the Maternal Mortality Ratio (MMR). According to Coovadia et. Al. (2009) citing Black & Bryce (2007), with 69 deaths younger than 5 years for each 100 000 live births, the nation's death rate is far in abundance of that, for instance, of Peru (25 deaths for each 100 000 live births), Egypt (35), Morocco (37), and Nepal (59).

South Africa exemplifies a nation that has gone through a protracted and polarised health transition as evidenced by the persistence of infectious diseases, high maternal and child mortality and the rise in non-communicable diseases (Sanders & Chopra,2006). It should be noted however that South Africa propelled a concerted national and state response to public health challenges through policy and legislative changes. The ANC's health plan which was published in 1994 was the post-Apartheid model for health system change. Under this, the new government achieved several successes. Primary health care, delivered through district health system was made the cornerstone of health policy (Coovadia et.al.,2009:828). Public health system was changed into a comprehensive national service. This was done with the urge to redress historical inequities thus providing essential health care to the

disadvantaged. In this regard, Primary health care became available at no costs to users. Cooper et.al. (2004:74) states that the introduction of free health care for pregnant women in 1994 improved women's access to appropriate care during pregnancy. User fees were scrapped for maternal and child primary health care services and in 1996 Nelson Mandela passed his first health legislation piece in office which was the Choice on Termination of Pregnancy. In 1995, there was a directorate that was established within the National Department of Health of Mother, Child and Women's Health. Its objectives were to increase women's access to proper health services and providing services to women and men that facilitated the attainment of optimal reproductive and sexual health amongst others (Cooper et.al,2004; Chopra et.al, 2009; NPPHCN,1997). There was a clinic infrastructure programme in which 1345 clinics were built and more than 200 upgraded and this improved the availability and access to healthcare services (Coovadia et.al,2009).

The National Health Act passed in 2004, saw the district health system and primary health care being defined as provincial responsibilities. Under the National Health Act of 2004, it enacted for a national health system framework integrating public and private sectors and the provision of equitable health care services. It provided for fulfilling the rights of children in connection to nutrition and basic services and entrenching the rights of pregnant women and children to free care throughout the public sector if they are not on medical aid. Section 4 of the National Health Act, gives when all is said and done the ways in which people (regardless of nationality) can gain access to health care services. It notes that pregnant and lactating women and children beneath the age of six are eligible for free treatment in public health care facilities. Other scholars have however argued that though the National Health Act guarantees access to health for all, migrant women having special health needs face challenges in accessing public health (Makandwa 2014; Zimmerman & Hossain,2011; Munyendwe et.al, 2011; Makandwa & Vearey,2017). Attention to maternal health of migrant women is still limited in South Africa. Where migration health policies do exist, they operate primarily in isolation at national levels and cover only fragmented snapshots of people's movements (Gushalak, 2010; Betts, 2010).

2.1.6 Gaps in Literature on Migrant Women's Maternal Health Issues

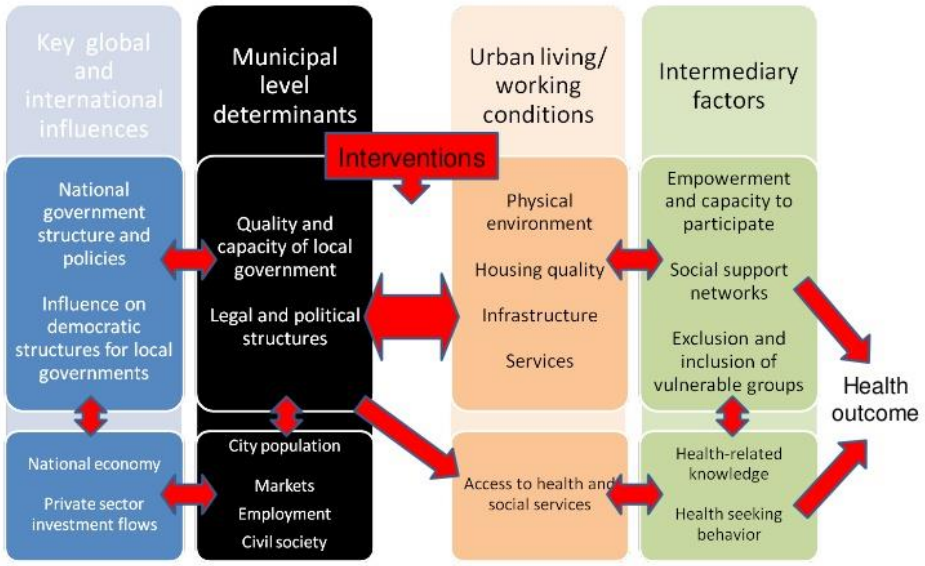
Various scholars have conducted research on access to maternal health of migrant women around the globe. It is however disturbing to note that large body of literature focuses on experiences and challenges being faced by migrant women in accessing public maternal health in different parts of South Africa. Little if any research has been conducted in terms of governance of maternal health using the case of migrant women and this study seeks to fill in this gap.

2.2 Conceptual & Theoretical Framework

2.2.1 Urban Health Framework

Conceptually this study adopted the urban healthcare framework. According to Galea and Vlahov (2005:343), factors affecting health in the cities can be considered in three themes namely the physical environment, the social environment, and access to health and social services. The urban health framework will help in unpacking health outcomes. However, it should be critiqued that the frameworks in urban health is relevant in explaining urban health but is silent on the issue of migration. Galea, Freudenberg, & Vlahov, (2005) proposes mechanisms through which a range of variables (physical, social, economic and political) may influence the living conditions that, they argue, are the primary determinants of the health of urban populations. The framework helps unpacking issues of health governance for this study. Recent predictions estimate that, "half of the world's populations will live and settle in urban areas by 2007 and three-quarters by 2030" (Galea, Freudenberg and Vlahov,2005:3). It is also estimated that the biggest cities will be in Africa, Asia and Latin America by 2030. This means that there is a rise in population growth, expanded survival and migration trends which deserves attention from public health professionals since the urban space influences every aspect of health, food people consume, housing and where they seek health care among others (Vlahov and Galea,2005). A better understanding of what causes health and diseases and how to improve public health entails an awareness of how urban-life itself affects well-being.

Galea, Freidenburg & Vlahov (2014:6) defines urban as, "a range of settings from city centres to peri urban fringe cities to densely populated isolated regions". They further state that this definition may hamper investigation of what is distinctive in urban versus non-urban living and its relation to health. Other urban scholars state that the diverse definitions of urban suggest a fundamental set of characteristics such as housing quality and access to health care services among others and these are driven to an extent by population size, density and heterogeneity are common to urban areas and shape the conditions of living within these areas. These factors have directly and indirectly shape health of urban populations (Galea, Freidenburg & Vlahov,2014).



Source: https://www.slideshare.net/chavanantsumanasrethakul/urban-medicine-meaning

Vlahov and Galea (2002:58) highlights that the three domains (social environment, physical environment, and health and social services) can be conceptually unified in a framework that may be useful in guiding research. The above diagram summarises and demonstrates that the health of urban populace is a component of urban living conditions, municipal-level determinants, global and national social, economic and political patterns (Galea, Freudenberg & Vlahov,2005). Urban living conditions portrays prompt conditions in which people live that is the people who surround them, their physical and social environments, and the range of available services. These living conditions are shaped by extensive municipal factors such as government, markets and civil society (Vlahov and Galea 2002) as illustrated by the table above. The model recommends that the most promising strategies for improving urban health are those that seek to make specific and targeted changes in these living conditions. This is because urban living conditions are hypothesised as the primary variable determinant of the health of urban population (Vlahov & Galea, 2002).

Different researchers comprehend the framework in different ways. Urban health researchers understand it basing their experience on the literature on the health of urban populations, whereas social and political scientist consider the model from left to right having in mind the broader social and political movements and how they influence municipal determinants that shape the urban characteristics that determine health (Vlahov & Galea, 2002:12; Galea, Freudnberg & Vlahov,2005). From the above diagram, Vlahov & Galea (2005) explains that the global and national social and political trends nature cities in the shorter term in the sense that they influence the previously

described urban processes and decide the resources available to a particular city or region. They identified these trends as migration and globalisation amongst others stating that these have powerful influence on the social conditions that determine urban health creating social and environmental exposures that determine cities impact on health (pg.13).

Municipal level determinants of health comprise of all government activities, local markets and the actions by civil society that operates at the city level. The interventions, popularly known as the public health interventions are the activities specifically organised for the purpose of improving the health of the public. These interventions may look to bring out changes both in municipal factors and urban living conditions specifically (Vlahov & Galea, 2005). The urban living/working conditions in the chart above portrays the attributes that shapes the day-day of urban inhabitants which is the proximate actualisation of all the above determinants. These incorporate population characteristics, for example, attitudes of individuals including their behaviours, the urban physical environment and the social environment such as social networks and finally the service system which either meets or neglects to address various needs (Vlahov & Galea, 2005). Lastly, is the health outcome, it represents the point of public health attention. This framework is suitable for this study as it focused on the governance of health of migrant women living in Jeppestown Johannesburg looking at the urban poor and the challenges faced in accessing maternal health in an urban space.

2.2.3 Governance of Health Framework

Frameworks for assessing the governance of the health system popularly known as HSG are of great importance for this study. It should be noted however that despite the growing discourse on governance, literature on governance of the health system is not particularly abundant. There is no set framework for governance of health and currently frameworks for assessing health governance systems do not exist (UNDP,1997; Kaufman & Mastruzzi,2005; Siddiqi et. Al.,2009. Lopez, Wyss & Savigny (2011:1) states that, *"While a number of frameworks for assessing governance in the health sector have been proposed, their application is often hindered by unrealistic indicators or they are overly complex resulting in limited empirical work on governance in health systems.*" Health systems are evolving, and this means that they have to continuously adapt to the ever changing demographic and epidemiological populations. Siddiqi et.al (2009:13) further states that governance of the health system is the least well-understood aspect of the health system. WHO Report (2000), defines health systems functionally as "all the activities whose primary purpose is to promote, restore or to maintain health". Frameworks for assessing health system governance (HSG) have been developed and tested in countries of the Eastern Mediterranean such as Pakistan and amongst these none can be adequately used to assess heath system governance. In this light, Wismar, Figueras, & Vasev (2016:4), argues that

the governance of a health system therefore shapes its ability to respond to the various well-documented challenges that health systems face today, and these include migration and the rise of chronic diseases and non-communicable diseases amongst others. Assessment of HSG should tackle health in its all-inclusive sense and not confine itself to provision of health services (Siddiqi et.al. (2009:15). Brinkerhoff & Bossert (2013) similarly comprehend health system governance as involving a range of governance agents, including providers and patients/citizens as well as the state, and the formal and informal rules shaping the relationships among them.

According to Pyone, Smith & van den Broek (2017:710), "*Governance of the health system is a relatively new concept and there are gaps in understanding what health system governance is and how it could be assessed*". They further state that health system governance is complex and difficult to assess simply because the concept of governance originates from different disciplines and that it is also multidimensional. There is a need to approve and apply existing structures and offer lessons learnt with respect to which frameworks function admirably in which settings. According to Verani et.al. (2011), conceptual frameworks can assist in clarifying the meaning of health system governance. Governance impacts all other health system functions, subsequently improving performance of the health system and ultimately better health outcomes (Siddiqi et.al., (2009). The improved performance of the ministries of health and state health departments is at the heart of the governance of health framework.

More recently, health system governance has been depicted as a collection of normative values such as equity and transparency within the political system in which a health system functions. Health system governance is presently a critical concern in numerous countries due to the expanding interest to exhibit results and accountability in the health sector. While the state has an unmistakable role to play in health care as the financier, regulator, coordinator and organiser of health services, the degree to which it should directly involve itself with the provision of health care is blurred, which influences how the health system is governed (Siddiq et.al., 2009). According to the UNDP (1997), good governance comprises of five principles which have a claim to universal recognition. These principles include accountability, fairness, performance, direction and legitimacy and voice. To this, Siddiqi et. Al., (2009:17) adapting the UNDP's principles of governance states that the UNDP governance principles provides a useful basis for developing a framework for assessing HSG. Though this framework is silent on the issue of migration, this framework is suitable in exploring the governance of maternal health using the case of migrant women living in Jeppestown as it relies on qualitative approach. This study still maintains the notion that focus was not on the Governance of Health systems and frameworks but the governance of the way that healthcare seekers (migrant women) experience in accessing public maternal healthcare in facilities.

2.2.4 Healthy Urban Governance

This study will adopt the healthy urban governance. According to Vearey (2011:1), "a revised, participatory approach to urban health 'concept mapping' is suggested which requires a recommitment to intersectoral action, 'healthy urban governance' and public health advocacy". Burris et. Al. (2007:i161), posits that the world's urban settings presents a huge opportunity to define and implement healthy public policy through governance innovation. With high urbanization rate across Africa, South Africa has the highest urbanization rate with an estimate of 60% population being urban (StatsSA,2011; Vearey,2011; Kok & Collinson,2006). The rate of urbanization especially in South Africa is due to in-migration and cross-border migration (Vearey,2011). Issues around urban health have been a matter of great concern over the last decade. There is the need to grapple with the impacts of urban living conditions considering factors that goes beyond the individual to the health of urbanites. To this, this study adopted the healthy urban governance as the overall conceptual framework as this assisted in unpacking the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown.

According to Burris et. al. (2007) urban governance is healthy, if it promotes a higher level and fairer distribution of health. Galea & Vlahov (2005) then states that it is demonstrating hard to indorse a high-level and fair delivery of health in the world's rapidly growing urban setting. Urban health promotion is not just a question of the right interventions or even the necessary resources but instead it depends to a more prominent degree on governance, the institutions and procedures through which societies manage the course of events. Scholars debate that healthy urban governance for health is in practical terms a venture for the powerless. In the urban setting, it turns on poorer residents gaining a greater share of control and resources (Burris et.al,2007). The voice of the poorer and those presumed to be socially marginal can be ignored. Shearing & Wood (2003) are of the view that urban settings frequently have vast populations of unlawful internal or international migrants whose right to participate is often challenged.

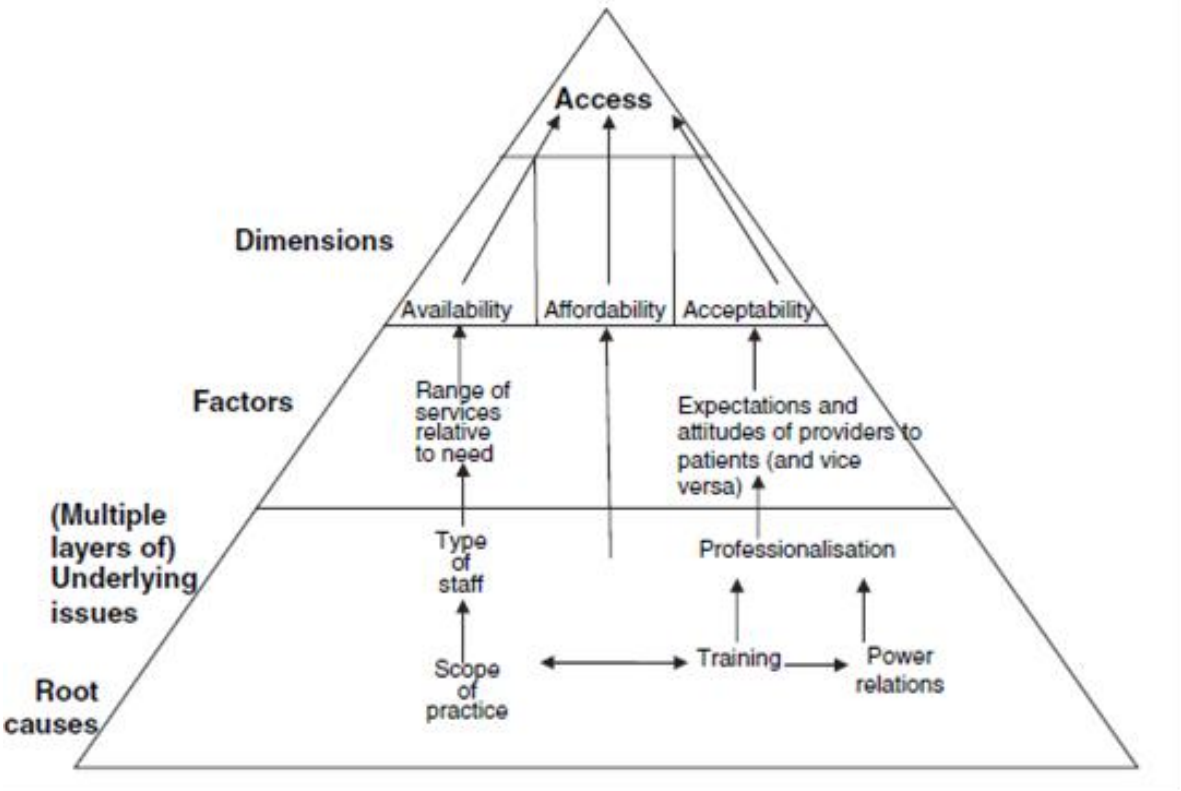
2.2.5 Conclusion

Health governance frameworks highlights the importance of governance in explaining how health systems function and achieve desired population health outcomes. Reviewed literature shows that the aspect of migration is not included in governance of health and the health system governance. Nations seem to turn a blind eye on migration when dealing with governance of health and when formulation frameworks for health governance. Abimbola et.al., (2014) citing van Olmen et. Al. (2012) states that the interest in health system governance stems on the expectation that good governance leads to improved health outcomes. Nonetheless, health system governance frameworks can be hard

to conceptualize due to the challenge of accounting for the roles and relations of a broad range of actors (Abimbola et. Al.,2014). Health system actors incorporates among others governments, groups of individuals who at various levels of authority, have the capacity and obligation to carry out health system functions which incorporates generating resources, deliver services, provide oversight or apply influence over decisions.

2.3 Access to health care framework

For theoretical framework, the study adopted the access to healthcare framework also known as the health access triangle coined by McIntyre. According to McIntyre et al (2009) access is based on three dimensions, which are availability, affordability and acceptability. To explain the framework, the study made use of the health access triangle below.



Extracted from McIntyre et. Al. (2009, pg. 190)

The above diagram illustrates the health access triangle based on availability, affordability and accessibility. This framework was relevant to my study as it assisted in unpacking the various dynamics between migrant women and healthcare providers. The framework acted as a guide in looking at the power relations between governance of health issues, healthcare providers and those seeking the services (healthcare seekers). Since this study was conducted in an urban space the framework guided in bringing out the various issues in migration and health discussions showing the similarities and

differences in types of migration and access to health care challenges faced by migrant women. It also aided in unpacking misconceptions presented by previous researches on the aspect of accessing public health in urban settings and the need for health policy to engage more broadly with mobility and health. Penchansky and Thomas (1991) states that availability refers to the fact that healthcare services are put in the right place at the right time to meet the needs of the people. Affordability refers to those costs for accessing services and sometimes the financial access in connection with the population's income (Thiede et. Al., 2007). Acceptability refers to the relationship between the healthcare provider and the patient in terms of attitudes and expectations, as these will influence the ability of individuals to receive care (McIntyre et al 2009).

Aday (1975:10), is of the view that there is need to grapple with the incidence, levels and types of use, or, indeed, and perhaps more essentially, non-use of services in terms of how (and whether) the health care system interacts with individuals, households, and communities. McIntyre et.al, (2009) posit that access to healthcare is usually identified as a goal for health policy, yet the exact meaning of access to health care remains unclear. McIntyre et.al., (2009:180) coined a conceptual framework that explains and defines access as a multi-facet concept that is grounded on the relationship between health care systems and individuals. They further state that:

"Access to health care represents the empowerment of an individual to use health care and reflects an individual's capacity to benefit from services given the individual's circumstances and experiences in relation to the health care system" (pg.181).

This implies that policies associated with access to care infer a commitment on decision-makers to not simply make administrations accessible, but rather to effectively engage people to utilize those administrations when required. The access to healthcare framework recognises access as the outcome of a process that involves the interaction between the characteristics of the health care service system and of potential users in a specified area, moderated by health care related public policy and planning efforts (Abdullah et.al, 1994).

The framework was also relevant in unpacking power relations in accessing public health care between healthcare providers and healthcare seekers. Foucault (1978/1990:2) states that power as actualised in the health care system can be understood as the expression of, "the multiplicity of force relations immanent in the sphere in which they operate." Various questions are pertinent to mapping out these power relations: At any given point in accessing healthcare services, who is in control? That is who has the upper hand? The Foucauldian perspective looks upon power relations as, "always local in scope and unstable, produced moment by moment and operating through successive confrontations and continuous struggles" (Eliassen,2013:17). Power is generally perceived as either having power over

something (dominant or sovereign power) or having power to do something. In the context of this study, the discussion is mostly about the power of healthcare providers, that is healthcare providers have power over healthcare seekers. Healthcare providers occupy a powerful position in performing their duties although they are constitutionally obliged to serve every healthcare seeker with respect and timely regardless of nationality (Makandwa,2014). Power relations in terms of access to health also assisted in unpacking various reasons why cross-border migrant women are unwilling to seek public maternal healthcare and also face challenges when they do.

Mclntyre et al (2009) states that access or empowerment to use healthcare services will only be achievable if all dimensions of access are addressed and both the healthcare system and individual perspective are considered. This access to healthcare framework therefore serves to represent the degree of fit between the healthcare seekers and the healthcare system (Thomas & Penchasky, 1984).

Conclusion

This research study on exploring the governance of maternal health is crucial in adding to the limited body of knowledge on governance of the way healthcare seekers experience in accessing public maternal health. With its substantive, extensive literature review and well-grounded question and approach, the study sought to explore the governance of maternal health using the case of migrant women living in Jeppestown, Johannesburg. Although most of the frameworks above are silent on the issue of migration, health system frameworks show the importance of governance in clarifying how health systems function and achieve desired population health outcomes. As stated above, literature on governance of the health system is not particularly abundant and there is no set working framework for governance of health and currently frameworks for assessing health governance systems do not exist.

Chapter Three: Research Methodology

3.0 Introduction

This chapter discusses the methods used to explore the governance of maternal health using the case of migrant women living in Jeppestown. It should be noted that by its nature as a Master's report the study is small scale. In this chapter I discuss the various strategies and methods I used when sourcing views from the selected participants. Overall, it will highlight the broader research design, target population, sampling methods, research instruments used during the process of collecting data as well as inform the ethical considerations that drew attention during the course of this research.

3.1 Designing a formula for the study of exploring the governance of maternal health using the case of migrant women living in Jeppestown

The research was moulded in the qualitative approach. I sought to understand people's experiences which I felt could not be quantified. The qualitative approach was suitable as it involves words that derive meaning in relation to people's experiences.

According to Denzin & Lincoln (2005):

> *Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including fieldnotes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.* (Denzin & Lincoln,2005:3)

The qualitative research approach is contextual and offers access to a valuable deeper and rich understanding of people's lives and behavior, including some knowledge of their subjective experiences (Creswell,1998). The study sought to establish the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown. The study required sourcing the opinions, reactions, responses and getting an insight from the key governance actors in the City of Johannesburg (Region F), including frontline healthcare staff, facility managers, regional managers, personnel staff and understanding the experiences of internal migrant women in accessing maternal health services at Jeppe clinic. In total, 20 semi-structured interviews were scheduled to be conducted. The qualitative research allowed me to get at the inner experiences of participants,

determining how meanings are formed through and in culture, and discovering rather than testing variables (Cobin & Strauss 2008:13).

Merriam (2009:3), defines a qualitative research design as an approach that seeks to 'understand the meanings that people have constructed.' For example, it refers to an expansive class of empirical procedures designed to describe and interpret the experiences of research participants in a context-specific (Denzin & Lincoln 2005). The qualitative approach was suitable for this research as it allowed the research participants to provide descriptive accounts and issues regarding governance of maternal health and issues related to migration and health. This then allowed for an in-depth probe and therefore, it became possible to establish the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown. The qualitative research approach embodies the nature of the study in which the views of the participants were accepted as subjective knowledge to gain an empathic understanding of governance of maternal health using the case of migrant women.

It should be noted that the method of inquiry involved multiple cases. From health care providers, personnel (nurses), facility and regional managers and frontline staff at Jeppe street clinic, health governance actors in the City of Johannesburg (Region F) and lastly external and internal South African migrant women seeking maternal health care services at Jeppe clinic. The use of multiple cases was for the simple reason that the research aimed to understand the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown specifically at facility level and this required multiple cases in a study involving an intense analysis and description of multiple units (Creswell 2003). Since this research was based on a case study, it was built on an in-depth contextual understanding (Yin, 2003) of governance of health using the case of migrant women living in Jeppestown and it relied on multiple data sources. Creswell et.al. (2003:245), then further states that "the case study research studies an issue explored through one or more cases within a bounded (i.e., a setting or a context)." To this, the research was based on a case study as it sought to deliberately cover contextual conditions that were highly pertinent (Yin 2003) to exploring the governance of maternal health. Case study research is a qualitative approach where the researcher explores a bounded system (a case) over time through detailed in-depth data gathering involving multiple sources of information such as interviews and observations (Creswell et.al.,2007).

According to Holloway & Wheeler (2002:30), qualitative research is "a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the way in which they live." Sherman and Webb (1988:15), then further states that, "*qualitative implies a direct concern with experience 'lived' or 'felt' or undergone."* This then means that qualitative research aims to get a

deeper understanding of experiences felt and lived by participants. Researchers make use of this type of research so as to explore perspectives, behaviours, feelings and experiences of their participants thus getting an insight of what lies at the core of their lives. My methodological strategy was aimed at exploring the governance of maternal health using the case of migrant women living in Johannesburg. The research aimed to specifically find out the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown. This strategy is best informed by Denzin & Lincoln (2005) who contends that qualitative research techniques should examine things in their natural setting in endeavouring to comprehend or interpret phenomena in terms of the meanings individuals convey to them. Creswell (2007:19) further goes on to state that the focal point of all qualitative research needs to be on understanding the phenomenon being investigated rather than solely on the researcher or the participants being studied. This strategy was of importance because it played a pivotal role by gaining insight into reality as understood and experienced by healthcare professionals and providers and also those experienced by migrant women in accessing maternal health.

Creswell (2007:37), states that qualitative research begins with assumptions, a perspective, the conceivable utilisation of a theoretical lens and the investigation of research problems inquiring into the meaning individuals or groups credit to a social or human problem. This means that, to investigate this problem qualitative researchers must make use of an emerging qualitative approach to inquiry, collecting data in a natural setting that is sensitive to the people and places under investigation, and analysing data that is inductive and establishing patterns or themes (Creswell 2007). The data was collected through in-depth interviews which allowed me to further generate questions basing on each participant's response. Interviews with the health care professional were all conducted in English. For the internal migrant healthcare seekers, I made use of a research assistant during the interviews who could speak the local languages. The research assistant had the necessary experience and had also previously did similar work in other studies. The language that was used to interview internal migrant healthcare seekers was Zulu, Xhosa and Tswana amongst some of the local languages. For external healthcare seekers English was used with some interviewed in Shona. The adoption of in-depth interviews allowed the researcher to further probe the participants for more information on the health governance issues influencing access to public maternal healthcare services of healthcare seekers in Jeppestown. What made this study unique was that it was not only limited to the perspectives of health care providers, but it also incorporated the healthcare seekers in this case the internal migrant women and some external migrant women so as to get both perspectives which then allowed for a comparison with other research that has been carried out which only focused on

experiences of cross border migrant women seeking public maternal health such as those conducted by Makandwa (2014), Pophiwa (2009).

3.2 Context and location of the study

The study identified Jeppestown as the study site. Jeppestown is situated in the periphery of the city of Johannesburg in South Africa and it falls under Region F of the city of Johannesburg Metropolitan Municipality. Migrant percentage in Jeppestown (internal and cross-border) is estimated at 47% and to this Jeppestown is migrant dominated and most of them are poor and depend on public clinics and hospitals (Johannesburg Population Survey, 2008). It has a total of 89,3% Black African population (JPS,2008). The Survey reveals that Jeppestown is migrant populated city with internal migrants coming in from all the nine provinces of South Africa as well as cross-border migrants from Zimbabwe, DRC, Malawi, Mozambique and Kenya among others. Initially it was just a light industrial area. Moreso, it should be noted that most of research was conducted at facility level, which is Jeppe clinic in Jeppestown.

Extracted from: https://www.google.co.za/maps/place/Jeppestown,+Johannesburg,+2094/

3.3 Target Population

According to Creswell (2003:32), target population is, "the total number of individuals who have certain characteristics of interests to a researcher." Target population, popularly referred to as theoretical population is the group to which we wish to generalise our findings. The population also refers to the units from which the sample is taken. In this research the sample refers to the key health governance actors in City of Johannesburg (Region F), including frontline healthcare staff, facility, clinic

and regional managers and internal and external migrant women accessing maternal health in Jeppestown that possess characteristics of interest to the researcher. Most of these were from the facility level (Jeppe clinic in Jeppestown), the Johannesburg Health District, Region F and the City of Johannesburg. This gave a holistic approach to understanding the crisis in governance and provision of healthcare, particularly for migrant women seeking to access public maternal healthcare. This facilitated in adding nuance to migration and health discussions and the need for health policy to engage more broadly with mobility and maternal health. The target population were interviewed by means of semi-structured interview schedule.

In this research, I made use of two semi-structured interviews. The first targeted health governance actors including frontline healthcare staff, facility, clinic and regional managers. This group was selected on the premise that they are responsible for health provision, responsible for formulation and implementation of health policies in South Africa. The second set of interview questions targeted internal and external migrant women/health seekers seeking public maternal health (ANC) in Jeppestown. To this, my target population was divided into two subgroups each represented by a different interview schedule.

Looking at the target population profiles, they differed in education attainment, job titles, age, work experience, profession, gender and age. The difference in dynamics have been identified by the researcher as shaping their beliefs, experiences regarding governance of maternal health and experiences in accessing maternal health. The first group that I interviewed consisted of the health governance actors (professionals, frontline healthcare staff, facility managers, regional managers among others) and the focus was to establish the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown. The second group consisted of the healthcare seekers seeking public maternal health at Jeppe clinic aged between 18-40 years who are of child bearing age, had attended ANC (Antenatal care) and at least given birth in inner city Johannesburg South Africa and currently pregnant and attending ANC at Jeppe clinic. I referred this group as “migrant women”. The reason for selecting this group was to establish and understand the experiences of internal migrant women in are accessing public maternal health and whether these experiences differ from those of cross border migrants basing on the research that was done on the experiences of cross-border migrants in accessing public maternal health such as those by Makandwa (2014) and Pophiwa (2009). The reason for interviewing the two groups was to get an insight from both sides of the story and this helped in coming up with a better judgement and understanding on the issues influencing access to public health of migrant women.

3.4 Mapping and Identification

Before conducting interviews, I started by mapping and identifying respondents.

3.5 Sampling

Purposive sampling was used in this study for the recruitment of health governance actors and the healthcare seekers. It refers to deliberately including participants with set experience and or knowledge needed by the researcher (Neuman, 2000). Purposive sampling is non- probability sampling method used to compliment the non- representative and non-generalist nature of the qualitative approach (Etikan et.al.,2016). A sample is referred to as a portion of population or universe (Taylor, 2005). For purposive sampling also known as judgement sampling, a researcher has something in mind and participants that suit the purpose of the study (Etikan et.al.,2016:1), in this case, the choosing of participants for the research lies on the researcher who then decides what ought to be known and sets out to find participants who can and are willing to provide information by virtue of their knowledge or experience (Bernard, 2002).

I chose purposive sampling so as to enquire the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown. It is characteristically used in qualitative research to classify and select the information rich cases for the most proper utilization of available resources (Patton,2002). Therefore, purposive sampling according to Takawira (2016) recognizes that research participants are not always created equal thus selecting only those individuals that will best enhance the research. Hence therefore, only health governance actors and migrant women (internal and external) seeking public maternal health care were targeted in this research. Snowballing was utilised to reduce this shortfall. Snowballing is getting participants through referrals from other participants (Babbie & Mouton, 2001). I made use of referrals for the health governance actors through the Johannesburg Health District where my research ethics clearance was granted and for the migrant women (internal and external). I also used referrals from Jeppe clinic where the women were attending ANC with the aid of the Jeppe clinic facility manager and the health promoter at Jeppe clinic. Snowball sampling was most appropriate as governance actors including frontline healthcare staff, facility, clinic and regional managers have been found to be conservative about sharing subjective issues (Governder, 2012). This type of sampling is usually used when the already sampled cases have knowledge of others with similar characteristics being studied.

A total of twenty participants (10 health governance actors and 10 healthcare seekers, 5 internal and 5 external) had been proposed to be interviewed. Out of the scheduled twenty interviews, only nineteen were interviewed. The main reason behind the shift and change was prompted by the

challenges I faced in identifying participants and setting up interview meetings considering that some of the health governance actors (regional managers) held top positions in the Ministry of Health and to this they were ever busy. The process of identifying participants also proved to be time consuming. In addition, getting hold of officials in the Johannesburg Health District and Johannesburg Health Metro in Region F also proved to be difficult as most of them reported being busy with their respective portfolios and some simply cancelled the interviews last minute due to work commitments.

The process of securing my research clearance from the City of Johannesburg (CoJ) and Johannesburg Health District was very tedious because of the intense vetting process and the bureaucratic structures by the District Research Committee. In reality, I had to wait for over three months before being issued with the clearance to conduct research in the city. This was because my research was targeting government health governance actors and also the fact that I was carrying out my research at facility level i.e. Jeppe clinic. This engulfed more time than envisaged and it delayed in the commencement of my fieldwork hence I was left with no option but to reduce the number of interviews that I had anticipated to conduct. I then put my emphasis on qualitative characteristics of the interviews (rich, deep, anecdotal experiences of the health governance actors) and their experiences on how health governance issues influence access to public maternal healthcare services of migrant women in Jeppestown. Instead of conducting 10 interviews with health governance actors I ended up conducting 9 putting into factor that this was the point of saturation as most issues were now being repeated at this juncture. The fieldwork started in January 2018 to beginning of May 2018 with most interviews being conducted during the month of March going forth when I had finished all the groundwork at the facility level (Jeppe Clinic), mapping, identification of participants and confirmation of interview dates and also after securing research funding. This gave me an opportunity to interact with the health governance actors and migrant women for lengthy periods of time.

3.6 Method of data collection & Data collection Tools

3.6.1 Semi-structured Interviews

Throughout the research process, primary data was collected using in-depth semi-structured interviews with the aim of accessing rich in depth narrative experiences. The main task of interviewing was to understand the meaning of what the interviewees were saying about their experiences (Kvale,1996). McNamara (1999) further states that interviews allows the researcher to pursue in-depth information on the matter of interest. Face to face in-depth interviews were used to collect data for this research. Interviews are especially helpful for getting the story behind a participant's experiences. The purpose behind using this method of data collection was to ascertain the health

governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown. In order to achieve this, I then found it necessary to frame interview schedules that would draw on how the health governance actors perceive the issues pertaining to access of public maternal health for migrant women.

Semi-structured interviews are purely conversations in which the researcher comprehends what they want to find out about and to this they have a set of questions to ask and a good idea of what topics will be covered. In this case, my conversations with my participants were free to vary and they changed significantly between participants (Miles & Gilbert,2005:65). In this study, two sets of semi-structured schedules were used with open ended questions. This did not only allowed the researcher to probe further but it also allowed the researcher to follow up leads with new questions during the interviewing process. The use of semi-structured interviews provided a more fitting format for conversing the sensitive topic of maternal health issues with both the health governance actors and the migrant women accessing public maternal healthcare. Other scholars are of the view that semi-structured interviews provide a flexible means of data collection in the sense that one can use them to build up a much deeper understanding of the research question by exploring contradictions within participants' accounts (Miles & Gilbert,2005). I made it a point that the schedule was brief, ensured the questions order was logical and developed a series of prompts. To this it meant that I knew the schedule inside and out. The interview schedule consisted of the main research topic themes, quotes from migrant women who were interviewed previously from other researches on access to maternal health, predetermined questions, no given responses and a series of response prompts, with no determined order (Legard, Keegan & Ward, 2003). The strength of the semi-structured interview is that the data given by the participants is rich, extensive, detailed and contextual.

The interviews were all tape recorded upon consent and participants were asked to fill in a consent form (See Appendix B). Tape recording the interviews was quite important to ascertain the validity and reliability of the research. Participants had an option to refuse being tape recorded if they were not comfortable. The interviews were conducted in English for the health governance actors. Plain language was used, and this allowed participants to internalize questions and respond to demands of each question. Each interview was scheduled to take 30-45 minutes and all participants were fully made aware. It should be noted however that most of the interviews exceeded the stipulated time frame as participants demonstrated their willingness to participate. This allowed me to probe for further depth and detail as well as clarity on any possible ambiguity. I was able to access private accounts of phenomena, beliefs and behaviour of respondents. All data collected through the interviews was treated within the strictest confidentiality.

3.6.2 Taking Qualitative Field Notes

I also made use of field notes for this study. These were simply notes that the researcher created during fieldwork to remember and record the behaviors, events and other features of observations and interviews. Fieldnotes are by definition written "in" the field (Sanjek, 1990: 64). According to Creswell (2013), qualitative research methods encourage researchers to take field notes to enhance data and provide rich context for analysis. Phillippi and Lauderdale (2017) laments that at first field notes were regarded as researchers' private, personal thoughts and inquiries with respect to their research observations and interviews. It is currently comprehended that qualitative field notes are a basic part of thorough qualitative research. Field notes were essential for this study since they supported in constructing thick, rich descriptions of the study context, encounter, interview and document's valuable contextual data. Field notes situate qualitative studies within a bigger societal and temporal setting thus providing nontextual auditory information about interviews, helpful in understanding participant meaning (Phillippi & Lauderdale, 2017). My field notes were not just comprehensive but also included critical reflections during and after data collection and this was useful in guiding my study. A well framed way to field note gathering was perfectly created before the study started and then purposefully revised based on findings to fuse new components while holding congruity of new things throughout the data gathering process.

Schwandt (2015) laments that field notes should be fleshed out as soon as possible after an observation or interview is complete. I took time to go through the jotted field notes after data collection and think through them thus reflecting on events, interviews and observations which helped in analyzing data. The convention of including field notes within qualitative research persisted as it provides information needed in analysis (Phillippi & Lauderdale, 2017). All the more in a general sense, other researchers contends that taking fields notes towards the finish of every session or day implies that the memory of real episodes and discussions will be still new in the mind of the researcher and permits the documentation of key focuses that informs the findings of the study (Moyo 2010). Others argue that depending on field notes in research has limitations as it traps one into textual fundamentalism as the text or field notes will become the basis on which analysis is concluded on (Fabian,2003). It was also a challenge for me, multi-tasking between taking down jotting during interviews and being attentive to the respondents' responses and keeping the interviews going at the same time.

3.7 Piloting the interview schedule

Pretesting the interview refers to interviewing participants to test if the interview schedule will elicit the necessary responses needed to address the research objectives (Legard, Keegan & Ward, 2003).

Pre-testing a data collection instrument should ensure the participants are able to interpret questions without difficulty (Hughes,2004). This is vital because if the respondent interprets the question in a different way to what was intended by the researcher, conclusions drawn from the respondent's answer may be flawed (Collins,2003). Creswell (2003) further laments that pre-testing works towards subjecting the questionnaire to an assessment procedure, to evaluate its capacity to gather the desired data, regardless of the measure of time and care spent by the researcher formulating the interview questionnaire. Pre-testing is the use of a questionnaire in a small pilot study to find out how well the questionnaire works (Hunt et.al.,1982). The pre-test can also be used as a device to estimate response rate for the interview schedule. Before the initial data collection, pre-test of the interview schedule was conducted. This was to ensure that the questions from the interview schedule were able to generate valid answers (Takawira,2016). The aim was to also ensure that the information gathered reflected the general views of all health governance actors in maternal health looking at health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown.

I selected three participants to participate in the pre-examination process. It should be noted that these participants did not participate in the actual study. The participants included one nurse, health official from Johannesburg Health District and one pregnant migrant woman from Zimbabwe. Through pre-testing the interview schedule practical aspects of establishing access and the actual interviewing were assessed as well as the quality of interviewing skills. During the pretest I picked up that there was hesitation at particular questions concluding that some questions might have been ambiguous, confusing or simply contained terminology that was unfamiliar to the participants (Hunt et.al.,1982). This allowed me to fine-tune the questions making them more precise and strengthening with follow up questions (Takawira,2016). Pre-testing was the best way to assess in advance whether the interview schedule causes problems for the researcher or the participants (Presser et.al.,2004). I took note of shortcomings in the research instrument and made sure these were resolved before the actual data collection process began.

3.8 Data analysis

Once data is collected, researchers are faced with the decision on how to analyse the data. Data analysis refers to the process of data management, description, interpretation and evaluation (Wolcott,1994). For this study, thematic analysis was used to analyse data and the research findings were presented in thematic form based on themes that frequently recurred in the data collected from the interviews. According to Braun & Clarke (2006), thematic analysis should be a foundational method for qualitative analysis as it provides core skills that will be useful for conducting many forms

of qualitative analysis. Babbie and Mouton (2001) define thematic content analysis as a process where emerging themes are categorized and interconnected and the write up of the research findings is guided by these emerging themes. This entails that data analysis is the process of making sense of the raw data that was generated in the research. This method of analysis was suitable for this study as it allowed the researcher to capture the meanings, experiences or events that shape the participant's perception of the social world and how people relate to each other.

Thematic analysis was based upon the theoretical positions of Braun and Clarke (2006). They define thematic analysis as a method of 'identifying, analyzing, and reporting patterns (themes) within the data' (Braun & Clarke,2006:79). According to Jugder (2016), citing Braun & Clarke (2006) this approach was chosen because it provides insightful analysis that answers particular research questions. It aided in complementing my research question by enabling an investigation of the interview data from a data driven perspective based on coding in an inductive way and from the research question perspective checking if the data were consistent with the research questions and providing ample information (Jugder,2016:3). I examined my themes basing on the context of my research question, research objectives and the discourse of governance of maternal health and migration. The data collected through interviews with health governance actors including frontline staff and internal migrant women was analyzed in three phases i.e., preparing the data for analysis by transcribing, reducing data into themes through coding and representing the data. Familiarization with data was internalized through transcribing and translation of the interviews (Jugder,2016). This was done through constantly listening to the interview recordings in order to have a precise translation and transcription. All interviews were transcribed verbatim by the researcher and this required the researcher's attention to detail.

3.9 Ethical Concerns observed before, during and after collecting sensitive data

Neuman (2005) states that ethics are essential for conducting effective and meaningful research. According to Moyo (2010) ethical research practice refers to values and rules of conduct in research and consultation. Throughout this research, ethical morals were observed and upheld encompassing the principles of informed consent, protection and welfare of participants, debriefing of participants, respecting participants' right to withdraw from research, maintaining confidentiality and anonymity of data among others. According to Lincoln (1995:287) these are termed relational ethics which recognises and values mutual respect, dignity, and connectedness between researcher and researched, and between researchers and the communities in which they live and work. Prior to data

collection, the research was submitted for approval to the Non-Medical Ethics Committee at the University of Witwatersrand and it was approved (with all data collection tools, consent forms, participant information sheet and tape recording consent forms) on 16 October 2017 under protocol number H17/09/20 (Attached on the Appendix). Since my study was also carried out at facility level i.e. Jeppe clinic and included health officials in Region F I required clearance from the City of Johannesburg which was to be applied through the Johannesburg Health District Research Committee. I handed in my application in September 2017 and only got it approved late December 2017. As stated before, the process of securing my research clearance from the City of Johannesburg (CoJ) and Johannesburg Health District was very tedious because of the intense vetting process and the bureaucratic structures by the District Research Committee. In reality, I had to wait for over three months before being issued with the clearance to conduct research in the city. It was however approved under NDRH Ref no: GP_201710_29 (Attached on Appendix).

According to Resnik (2015:2) one may define ethics as a method, procedure, or perspective for deciding how to act and for analysing complex problems and issues. During and after conducting a study, researchers are encouraged to reflect on their research actions thus consulting their conscience (Neuman, 2000). In this study, I made it a priority to ensure that participants who took part in my study did not face any physical, psychological or legal harm during and after taking part in the study. Given that the study focused on governance of maternal health using the case of migrant women, issues that had been indicated might have led to psycho-social challenges, the researcher acknowledged that participation might evoke feelings of distress or cause psychological harm. Participants were advised therefore that should this happen, they will be referred for counseling if need arises (Babbie & Mouton, 2001).

I made it a point that I first introduced myself, explaining the nature, procedure and purpose of the study. Appropriate information on the aims of the study, duration, procedures and the credibility of the researcher were clearly outlined and explained to the participants through the information sheet (De Vos, Strydom, Fouche & Delpot, 2001). Informed consent and voluntary participation were prioritised before data collection began. That participants were also informed that they had the right to withdraw from the study at any time without being made feel guilty or threatened. The participants were informed on issues of anonymity and confidentiality of records being secured making sure that participation was voluntary. Participation in this study was not going to yield any monetary benefits or compensation and participants were fully made aware of this. None of the participants were coerced to take part in the study or promised any incentives. All these issues were clearly stipulated and explained by the researcher verbally and by means of a participant information sheet that the participants signed upon agreement to participate in the study.

Anonymity and confidentiality were of great importance for this study. Anonymity was guaranteed by the use of pseudo names for both the migrant women and healthcare officials. It should however be noted that for the health care officials it was explained to them that even if the researcher will use pseudo names in the final report, anonymity would not be guaranteed considering the fact that the researcher carried out the study at facility level using a small population sample and that participants might be identified because of their respective work titles. Participants were also assured that collected data would be used for academic purposes and available only to the researcher and the supervisor. Interviews were tape recorded and this required the participants to sign on the consent form upon agreement. All interviews were carried out at facility level (Jeppe Clinic), Johannesburg Health District offices (Region F) and these were all secure places where participants were comfortable. Participation in the study gave all recruited participants an opportunity to present their views concerning their life experiences on issues to do with migration, governance of maternal health and maternal health.

Participants were informed that the thesis of the study will be available at the University of the Witwatersrand library and an abstract will be made available to them if requested. Furthermore, their names will not be mentioned in any documentation or presentations regarding the study.

3.9.1 Challenges, drawbacks and limitations faced during data collection

It should be noted that this research was carefully planned, however, I still faced a number of challenges and drawbacks during fieldwork.

The gender, position or profession of the researcher as argued by Carling et. Al. (2013) is a fundamental element of social identity that affects the experience of sameness or difference and this placed the researcher as an outsider. Considering that I was a university student interviewing professional in the health sector, policy implementers and migrant women (internal and external) accessing ANC, there were challenges as some respondents were not comfortable to open up during interviews. This can be attributed to the issue of positionality of the researcher. Positionality in qualitative research alludes to the way that a researcher's characteristics affects both substantive and practical aspects of the research process from the nature of questions that are asked, through data collection, analysis and writing, to how findings are received (Carling et.al.2013:2). In my case focus was on positionality in the field and how my position affected access to and interaction with participants. However, since the study was done at facility level, I made use of health care providers and the facility manager to introduce himself to the participants and also I would spend more time

around the facility which helped especially with the women seeking ANC at the clinic as they eventually became comfortable around me hence opening up. Also, I made use of other researchers who were carrying out almost similar studies within the inner city (Johannesburg) including Jeppestown as an entry point to gain access.

Although funding was a challenge, the issue of concern for the researcher was of navigating the city and space in which the research area (clinic) was located and also Region F which included mainly Hilbrow because that is where the Johannesburg Health District offices are located. I was concerned with navigating the city considering issues of safety and crime in the inner city and the periphery of Johannesburg. My safety and security in this regard was put into consideration especially looking at issues of crime and Xenophobia in Johannesburg (South Africa). Violent crime remains an ever-present threat in South Africa and Jeppestown is highly known for crime, xenophobic violence and attacks. The fact that I am also a non-national in South Africa also exposed me to risks of being attacked and mugged in the city. However, I made use of safer transport modes such as Uber and Taxify to get to the research sites to avoid risks of getting attacked and mugged.

The issue of language was also a barrier during fieldwork. Most of the people were Zulu speaking and to this the researcher was using English to conduct the interviews. Some of the participants would struggle to express themselves in English and this could have distorted the quality of data collected. However, simple English was used so that the participants were free and comfortable to express their experiences regarding issues to do with governance of maternal health. Also, for the internal migrant women, I made use of a research assistant who then interviewed the women and transcribed the interviews.

Another challenge was setting up of interview dates and time. It was difficult to arrange for the actual interviews to be conducted after identifying participants. The main reason was that some of the health governance actors held top positions in the ministry of health and to this they were ever busy. The process of identifying participants also proved to be time consuming. Some participants even cancelled the interview on the day it was supposed to be conducted and this took up much time of the researcher making calls and setting up appointments.

3.10 Conclusion

The process of establishing the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown was made possible after my participants were categorised into two groups i.e. the health care providers and the migrant women seeking ANC at Jeppe clinic. Participants were purposively selected and interviewed using a semi-structured interview

schedule. This enabled the researcher to collect rich anecdotal information regarding issues to do with migration and governance of maternal health.

Chapter Four: Research Findings and Discussion

4.1 Introduction

This chapter will present the findings and discussion of the study. It will try to answer the research question trying to interpret the findings within the conceptual and theoretical framework of the research report. The findings were based on the need to find out the health governance issues influencing access to public maternal healthcare services of migrant women using the case of Jeppestown. Following an intense reading of transcripts, salient topics were picked separately for each transcript/interview. Central topics that recurred separately across interviews were listed and analyzed in more detail. This chapter draws on themes from the interviews conducted. The chapter will give some nuanced discussion of the findings. The findings presented in this chapter make use of constant and specific reference to verbatim quotations from the interviews and field notes conducted with participants in the study. A table of themes that emanated from the study will be used, and background demographic information of participants summarized in a table. The participants table begins with the names and titles of the health care providers followed by the migrant women's table (internal and external migrants). It should be noted that participant's names do not represent their true names, pseudonyms were used for this study.

Table 1: Information Of Health Care Participants

PARTICIPANT'S PSEUDONYM	***JOB TITLE***	***WORK STATION***	***REGION***
P1 (Nombuso)	***Project Manager/Assistant Director Maternal, Child & Women's Health***	***Johannesburg Health District***	***F***
P2 (Lerato)	***Healthcare Worker***	***Jeppe Clinic***	***F***
P3 (Nomagugu)	***Advanced Midwife/Maternal Health Nurse***	***Jeppe Clinic***	***F***
P4 (Nkosana)	***Deputy Director Infection, Prevention & Control – Primary Health Care***	***Johannesburg Health District***	***F***
P5 (Mary)	***Antenatal Nurse/Maternal Health Nurse (Pensioner Nurse)***	***Jeppe Clinic***	***F***
P6 (Thando)	***Professional Nurse under Family Planning***	***Jeppe Clinic***	***F***
P7 (Lebohang)	***Facility Manager***	***Jeppe Clinic***	***F***

P8 (Sithembile)	*Student Nurse*	*Jeppe Clinic*	*F*
P9 (Gugulethu)	*Deputy Director Primary Health*	*Johannesburg Health District*	*F*

Table 2: Information of Migrant Women Participants

Internal Migrant Women

PSEUDONYM	*AGE*	*PROVINCE*	*Duration in Living in Inner City Johannesburg*	*No. of Children*
Sandra	*30*	*North West*	*4*	*2*
Thokozani	*25*	*Eastern Cape, PE*	*5*	*2*
Rendani	*26*	*Limpopo*	*6*	*2*
Yoliswa	*34*	*Eastern Cape, Mzimkhulu*	*5*	*3*
Snobani	*28*	*KZN, Nquthu*	*6*	*1*

External Migrant Women

PSEUDONYM	*AGE*	*COUNTRY*	*Citizenship Status*	*No. of Years in South Africa*
Tanyaradzwa	*26*	*Zimbabwe*	*Passport with no permit (Passport Stamped Out)*	*5*
Amidah	*33*	*Tanzania*	*Asylum*	*7*
Chimwala	*39*	*Malawi*	*Passport No Permit*	*8*
Kantayeni	*25*	*Malawi*	*Passport with No Permit*	*4*
Esther	*30*	*Zimbabwe*	*Passport with work permit*	*6*

Table 3: Overall Themes and sub-themes that emanated from the study

It should be noted that the themes and sub-themes below do not represent or reflect the only health governance issues influencing access to public maternal healthcare services of migrant women because health system governance is complex and difficult to assess simply because the concept of

governance originates from different disciplines and that it is also multidimensional. Therefore, the conclusions drawn from this report do not lend themselves to an all-inclusive application as they are specific to the case of interviewed migrant women living in Johannesburg. The themes below were the most recurring for this study and I deem them to be crucial and worth discussing.

The Paradox of Free Health Care Access: The Twofold Narrative • Abuse of Free Access to Health by healthcare users • Health Policy Implementation is non- Inclusive	*Much as we would want to plan for them, we can't plan for them. Remember we have also the financial constrain as a country. The fact that health care at the District level is a free service it has a huge negative implication because people are now abusing the system. People would go and get medication in Facility A, the following day go to Facility B. One week a person would have travelled 5 clinics if not 10 because in the morning she goes to this one and in the afternoon another one just collecting medication and we don't know what this medication is used for. We don't know whether it's used as part of concussion of drugs that arrive in the country. We don't know whether these women are opening mini- pharmacies and selling these drugs. We don't know! But there is a market there somehow of this medication. You can't be having free medication from three facilities, even two. It's too much!* ***(Interview: Gugulethu).***
Linguistic Barrier: A Challenge to the Provision of Equitable & Effective Healthcare for Migrant Women	*The way they speak, sometimes they are unable to speak the common language that we speak in our area and it's very, very difficult to communicate with them because that is the main challenge. Again, that it is difficult to speak to those people because if they don't have interpreters it's very difficult even to get history from them. You find that the woman is pregnant, you want to know how long she has been pregnant, has she had any previous complications, whether the first baby was delivered by Caesarean or whatever…it's very, very difficult we don't know how to communicate with them and it's very difficult to collect information from them* ***(Nombuso,).***
High Influx of Migrants Causing Health Budget Constraints	*You know what, I think it does because as people come in, with the stats that we have of people coming in….* L*et's say for instance the 25% are from Soweto and they moved to stay here in town. They belong to the city of Joburg those ones. I am talking of the other 75%. You know before clinics used not to be this full, we used to open two days even a*

	day a week but now we have to run everyday even with the preventative, the booking, the family planning and the TB. Now we have to work every day because of the influx of the people coming from the homelands, coming from foreign countries. It affects the budget too because we budget for a certain number of population ***(Interview: Lebohang).***
Staffing & Staff Burnout	*Yah, obviously if you have greater volumes you know, you would have staffing issues, you would have infrastructure issues, you would have resource issues. Staffing issues there would be a lot of burnout because the staff can do so much with limited resources and then our infrastructure sometimes cannot hold all those great numbers* ***(Interview: Nkosana)***
Initiation of ANC: A governance of maternal health concern • Late Booking & "Unbooked" Cases in ANC	*Maternal healthcare challenges that we see, we have a lot of migrant women who would come in the country or in the province on the eve of their delivery. They didn't attend antenatal care clinics, so we couldn't pick up whatever challenges.* ***(Interview: Gugulethu)***

Comparative of internal migrant experiences versus external migrants

The comparative will focus on migrant women's experiences and their narratives and then make a conclusion whether internal migrant women experience the same challenges that are faced by external migrants.

4.2 The Paradox of Free Access to Health: The Twofold Narrative

Within the broader framework of governance that emphasizes free access to health, in South Africa the question of free access to health is pertinent considering the legacy of Apartheid. But also the health conundrum that many especially amongst the poor it is a policy that was put in place to ensure that there is free access to health for the poor communities after Apartheid and as part of fulfilling the then Millennium Development Goals (MDGs). However, on the other hand is the context through which free access to health has created a panacea within the system. This is especially in terms of access, consultations, dissemination of drugs at an administrative level where lack of access and shortage of drugs is now being associated by those that are at administration level with the problem of abuse, overuse and misuse of free access to health care services.

Health care providers were also of the view that free access to health is a good initiative, but the question asked is who deserves free access? In addition, how well and inclusive was the policy

implementation and lastly whether the policy is not divorced from reality on the ground. Whilst on the other side migrants claim they are being denied access to free health. This creates a lot of binary contradictions because while the providers are disseminating drugs on one hand, these drugs are now finding themselves on the street market being either resold for drug abuse purposes or even for cash retainment purposes by presumed migrants accessing free health care in facilities. This has resulted in providers keeping some kind of foothold on free access to health. This then leaves the policy itself in a conundrum on what direction should be taken and also whether the problems should be linked to policy implementation process thus having an influence on healthcare seekers accessing maternal health. The theme of the paradox of free access to health is a crucial theme in the health governance issues influencing access to public maternal healthcare services of healthcare seekers as participants raised great concern on the issue. The following sub-themes on the paradox of free access to healthcare will give further analysis on how healthcare providers' expounded on how free access to health has created a panacea within the maternal health system which then influences access for healthcare seekers.

4.2.1 Abuse of Free Access to Health by Healthcare Users

Issues around free access to health were continuously raised during the interview sessions with the healthcare providers. This research found out that the policy of providing free access to health has various implications on its own in terms of governance of health in as much as it is a noble thing. After 1996, various South African national health policies were introduced and among these was the implementation of the free care (removal of fees). Of significance here is the policy change through the implementation of free care combined with the removal of user fees both for services provided to pregnant and lactating women and children under six in 1994 and for all public primary care services in 1996. The aim of these policy shifts was to improve access to health services for the previously disadvantaged communities after the end of Apartheid. This study has identified that frontline healthcare providers popularly known as Street-level bureaucrats have raised issues around free access to health policy as a matter of great concern to them and having problems as far as governance of health is concerned which in the end has consequential effects in migrant women accessing maternal healthcare. Healthcare providers are of the view that women especially external migrant women accessing free maternal health care are abusing the free services available to them through multiple consultations and going from one facility to the other collecting medication which they believe this medication is being used for business purposes. A classic emblematic example demonstrates the conflict of expectations that exist between the street-level bureaucrats and supposed beneficiaries which in this instance are the migrant women seeking maternal healthcare:

Much as we would want to plan for them, we can't plan for them. Remember we have also the financial constrain as a country. The fact that health care at the District level is a free service it has a huge negative implication because people are now abusing the system. People would go and get medication in Facility A, the following day go to Facility B. One week a person would have travelled 5 clinics if not 10 because in the morning she goes to this one and in the afternoon another one just collecting medication and we don't know what this medication is used for. We don't know whether it's used as part of concussion of drugs that arrive in the country. We don't know whether these women are opening mini- pharmacies and selling these drugs. We don't know! But there is a market there somehow of this medication. You can't be having free medication from three facilities, even two. It's too much! ***(Interview: Gugulethu).***

The above quote highlights that healthcare providers view the free care policy as a cause for concern to them. A substantial body of literature reveals that the impacts of free care have been multiple and varied (Walker & Gilson, 2004:9; McCoy, 1996). Most healthcare providers raised issues stating that the fact that migrant women are mobile in the city, they have resorted to moving from one facility to the other collecting medication and they resort to multiple consultations therefore abusing the system as highlighted by the above quote. Concerns were raised on whether some of these women genuinely need access to health or they simply do not need it, hindering the genuinely needy from accessing care. Some healthcare providers have then raised eyebrows on issues whether free health care should benefit some but not all. This has affected governance of health especially in maternal health as Gugulethu notes. In this regard one can clearly denote that Gugulethu was expressing her perceptions and perspective regarding policy implementation of free access to healthcare which equates to governance of health issues and how it has had repercussions in migrant women accessing public maternal healthcare at ANC stage for example.

Mclyntre & Ataguba (2014:1) express that access relates to opportunity to obtain and appropriately use quality health services and this is concerned with the "degree of fit" or compatibility between the health system and individuals who need to use these services. Access to services whether essential such as health, housing or education affects how people obtain what is necessary to satisfy their needs and wants (Brezzi & Luongo,2016). Moreso, access to health services means the auspicious utilisation of personal health services to attain the best health outcomes and the South African Constitution guarantees everyone access to health care services. This implies that in terms of the South African law and jurisprudence all South African residents and migrants are therefore entitled to access free primary health care services. The right of access to health care services is one of the indivisible and interdependent rights entrenched in the Constitution of the Republic of South Africa Act, 108 of 1996. While such enormous endeavours have been committed to these initiatives, different reactions and concerns have been raised by healthcare providers over abuse and overuse of free healthcare services.

Health care providers have noted with concern during this study the issue of multiple consultations, moving from one facility to the other collecting medication which they believe is used for business purposes and to make other drugs that are sold in the streets.

In this study, free access to healthcare has raised issues as far as governance of maternal health is concerned. Healthcare providers complained that migrant women both internal and external are doing what they term "double consultations" whereby they visit different facilities in one day thereby abusing and wasting resources. Though the scanty available evidence on impacts of free access to health suggest that it led to noteworthy upsurge in healthcare utilisation levels (Walker & Gilson, 2004), this study discovered from the providers that free healthcare has actually led to overuse and abuse of state resources.

Another student nurse beamoned the notion of free access to health noting with concern how migrant women move from one healthcare facility to the other consulting and collecting medication especially family planning pills which she believed they then resale them to their friends and networks with some even taking them back home for resale. She notes that:

> *Access to health is free and this is what the Constitution says. We cannot deny anyone access to health when they come here to seek health services. We however have these women whether pregnant or not who go around clinics during ANC visits and they are given medication free of charge be it family planning pills or whatever and these are mostly non- South Africans. I am a student nurse and as student nurse we rotate around clinics and district hospitals, so we get to meet these women in most of these facilities. I am sure they take the medication they get here and sell it after especially family planning pills. Free access to health is a good policy initiative but the moment one takes advantage of it in this way collecting medicine around clinics then surely there is a problem. At times we run out of stock and those who need the medication desperately will suffer because stocks are out, and we are forced to make necessary plans as facilities to make sure we provide medication and treatment. You see**. (Interview: Sithembile).***

The above sentiments indicate a strong perception of how one health care provider views are expressed about the negative impacts of free health which has led to governance issues affecting and influencing migrant women in accessing maternal health. Free access has generated a scenario where beneficiaries are abusing the free access available to them. Beneficiaries are believed to be shopping around between clinics and coming from other countries and rural areas to access free health (Walker & Gilson,2004) thus placing a burden in terms of workload to the healthcare providers which will be discussed in themes to follow. This draws back to the issue that migrants are the ones believed to be abusing free access to health policy both internal and external as noted by Walker & Gilson (2004) supporting the notions raised from the two quotes. This study found out from the interviews conducted that there was a logical contradiction between recognising the value of free access to

health whilst upbraiding the extremely same policy for resulting in abuse, misuse and overuse of the system. This study has also brought to light through interviews conducted how healthcare providers values and perspectives impact their reactions and responses to the access to free health care policy.

Sithembile noted with concern that facilities end up running out of stock due to the women who go around facilities clinics shopping medication due to free access and this leaves a burden on the health care providers. In the long run, it brews negative impacts on their morale and attitudes and the end result is taking it out on the women accessing maternal health thus it has an influence in terms of migrants accessing maternal health. All these issues are linked to governance of maternal health. At this juncture, questions were raised regarding the implementation of free access to health policy. The following sub-theme will now go on to look at the issues raised by the healthcare providers in terms of implementation of free access to health.

4.2.2 Implementation of Healthcare Policies are non- Inclusive

Responses on the implementation of free access to health were varied with most health care providers and front–line staff raising concerns of not being involved and consulted during implementation of such policies which then leads to the above worrying outcomes (abuse of free health) of often good policies. Chopra et.al. (2009) laments that progressive policies and numerous positive initiatives notwithstanding, implementation remains a worry in South Africa. One maternal health nurse had this to say when asked on implementation of such policies:

> *I think they should include…You see what happens, the problem when policies are made, people who work with these people are not invited. You understand. I am not invited when policies are made. If you include people who work with these migrants, then when drafting policies, you get an idea that this is, what is supposed to happen in terms of your National Health Act and so forth. Because things like this new National Health Insurance I am not sure if will it cover foreign nationals who are migrants. You understand. So, involve those people who work with these migrants when drafting policies because they have got a lot to contribute. You understand. So, include people and educate them (***Interview: Nomagugu)**.

The above highlights resentment due to the lack of consultation and exclusion of healthcare providers including frontline staff in the planning and implementation of the so-called health policies. Walker & Gilson (2004) citing Hill (1997) state that the gap between targets and results is a demonstration of how policy is recreated through the process of implementation, rather than an implementation failure. This supports Nomagugu's quote because in this study, frontline staff complained that they must have relevance by being included in implementation of policies such as health care because they are the ones responsible for providing these services and to this they must have discretion in taking

decisions that will enable them to react viably to those who seek health. A senior respondent in the health district had the same sentiments that they are not involved in implementation and are only given directive to deliver after implementation is done. She notes:

> *Most of the time they come up with policies and they give us and say implement. Remember we are the implementers. They would go maybe to our (pauses), like the District Head, the Chief Director they will maybe go to her in their other senior meetings. Much as I am a senior manager, there is other people who are more senior than me. People who are sitting in the meeting with the MECs, so there are people that are sitting in the meeting with the HOD and the DDGs. So those people they are the ones. We do now and then get involved but not at the level where I would say it's proper consultation. Some things we do get involved, some things we just get an instruction that says implement this and we take it that it's our superior they know. You can't query not because you are a coward, you can't query because you trust these people that are taking decisions because they are professionals too. They know what is happening and we write reports to them, so from the perspective of Public Health, those people should be able to advise to the policy makers* ***(Interview: Gugulethu)****.*

While a substantial body of literature reveals that impacts of free care have been multiple and varied (Walker & Gilson, 2004:9; McCoy, 1996) and other suggesting that impacts of free access to health suggest that it led to noteworthy upsurge in healthcare utilisation levels this study discovered from a paradox of free health from the providers that free healthcare has actually led to overuse and abuse of state resources by women accessing maternal healthcare. It also discovered that healthcare providers raised concerns of lack of consultation and exclusion of healthcare providers including frontline staff in the planning and implementation of the so-called health policies which then leads to negative outcomes of often good policies as noted above and this leads to migrant women accessing maternal health care to often experience challenges. All these are health governance issues that came up in this study and have a bearing on the factors that influence access to public maternal healthcare services of migrant women. Dogson, Lee & Draker (2002:6), posits that "health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population."

The following theme will go on to explore the issue of language which all the healthcare providers deemed to be a great challenge to the provision of equitable and effective heathcare for migrant women.

4.3 Linguistic Barrier: A challenge to the provision of equitable and effective health care for migrant women

The respondents dwelled much on the issue of communication as a serious challenge as far as health governance is concerned. Healthcare providers complained that communication with the migrant women especially the cross-border migrant women is a big challenge contributing to their experiences in accessing healthcare. This study found out that communication between healthcare providers and migrant women is hindered because they do not speak the same language. The healthcare providers raised concerns that they could not get the history of the migrant women when they came for maternal healthcare services because of the language barrier which is a major problem in facilities leading to experiences faced by migrant women causing challenges in governance of maternal health. Language is very important in health provision especially for accurate and effective history taking and when establishing rapport and trust between the healthcare provider and the patient. An interview with Nombuso, the project manager for Maternal health shows evidence that communication barrier is a major hinderance and in situations where there are no interpreters available it is almost impossible for the healthcare providers to engage with the migrant women when they come for ANC visits, consultations, delivery or seeking any maternal healthcare services:

> *The way they speak, sometimes they are unable to speak the common language that we speak in our area and it's very, very difficult to communicate with them because that is the main challenge. Again, that it is difficult to speak to those people because if they don't have interpreters it's very difficult even to get history from them. You find that the woman is pregnant, you want to know how long she has been pregnant, has she had any previous complications, whether the first baby was delivered by Caesarean or whatever…it's very, very difficult we don't know how to communicate with them and it's very difficult to collect information from them* ***(Interview: Nombuso).***

The quote above demonstrates how linguistic barrier between the healthcare providers and the migrant women seeking maternal healthcare services is a profoundly rooted structural feature of the public health system incumbering the provision of equitable and effective access to health making it a health governance issue. South Africa has eleven official languages and numerous non-official languages (Deumert, 2010) with a diverse of ethnic groups and the presence of international migrants or other populations especially in Johannesburg. Language and communication are vital for equitable and effective health delivery in heteroglossic, multicultural and multilingual societies. Although Johannesburg is a migrant (internal and external) dominated city, the popular and most common home language that is mainly used by the locals is Zulu. The National Health Act (2003) however, states that health providers must inform patients in a language they understand about their health status

and treatment options, but it is silent on the issues of providing interpreters. All the health care respondents interviewed raised the issue of language barrier stating that there is a major barrier to access to health services if one cannot speak or communicate in the local language. The study found out that with the internal migrants, communication barrier between the healthcare providers and internal migrant women was not a challenge: *With internal migrants it is better than outside migrants. Whether you are Venda, Shangani or whatever we can talk and understand each other* ***(Interview: Lerato).***

Hussey (2013), states that overlooked language barrier remains a challenge in providing healthcare in South Africa. The study found out that English was the common language used by healthcare providers when interacting with non-nationals who came to seek maternal healthcare but most of the healthcare providers were reluctant to speak English preferring their vernacular or local language when attending to non-nationals. The migrant women interviewed in this study also complained on issues of language barrier and how they are ill-treated when they speak in English with healthcare providers, but this will be discussed in themes to follow when looking at the comparative of migrant women (internal vs external) experiences in accessing maternal health care. The issue of linguistic barrier leads to othering of non-nationals by the healthcare providers as they cannot speak local languages and providers are of the habit of asking these women to bring their spouses, friends or interpreters whenever they come to seek maternal health care services which then compromises issues of privacy and confidentiality when seeking healthcare. Lerato notes:

> *The challenge is the language barrier. You know, some of the women who are coming for services they are coming from outside the country. Whereby we speak different languages then it's a big challenge to communicate. It's a communication barrier between us and them. Until we search for someone who understands the language from this country who is coming outside South Africa to interpret the information that we give. So, it's very big of a challenge. As you know that when you deal with patient you have to keep privacy, so we break a little bit of the rules when it comes to interpretation. Because we as staff we don't have someone from outside the country who is working in our health department meaning the clinic. In my clinic, Jeppestown clinic we don't have someone speaking those languages* ***(Interview: Lerato).***

Lerato's sentiments reflects migrant women coming from different countries into South Africa for healthcare services (maternal) but then the issue of communication becomes a challenge as healthcare providers cannot get interpreters. Deumert (2010), notes that hospitals are ill-equipped to respond to the linguistic challenges brought about by migration. Vearey (2011) is of the view that migrants constantly struggle to communicate with healthcare providers as interpreters are not present. Vearey's notion is also at par with various international findings whereby linguistic barrier is considered a primary challenge for meeting the healthcare needs of immigrant population (Kale &

Kumar, 2012). The issue of interpreters raises eyebrows as far as healthcare provision is concerned which is a health governance issue. It is marred by questions of compromising privacy, confidentiality and issues of informed consent especially when it comes to sensitive issues such as HIV testing during ANC for example. The Johannesburg Health District emphasises and is clear on confidentiality and privacy, yet these are breached left, right and centre when healthcare providers involve third parties when attending to patients seeking healthcare due to language barrier. The healthcare providers are left with no option but to breach privacy when they ask the non-nationals to bring friends, spouses or interpreters when coming for their ANC visits and maternal healthcare services:

> *Another thing is communication. We do get, you know communication barrier. So, at times we ask the clients to either bring a note from the person they are staying with or must be accompanied by somebody* ***(Interview: Mary)***

Literature reviewed highlighted that maternal health administrations were described by lack of privacy furthermore, women encountered access problems due to language differences between providers and the women (Rees,1994; Cooper et.al, 2009; Coovadia et. al.,2009; Chopra et.al.,2009; Bradshaw et.al., 2000; Sanders & Chopra,2006; Vearey,2010). Interpreting in healthcare according to Deurmet (2010) is fraught by problems of accuracy and confidentiality. Dogson, Lee & Draker (2002:6), posits that "health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population." This notion clashes with the issue in discussion simply because measures are not put in place to accommodate those who cannot speak the same language as the healthcare providers in the event that they seek healthcare services in the end they are asked to go an extra mile of getting their own assistance in the form of interpreters for them to get health services. Yet the National Health Act (2003) recognises non-nationals and gives provision that health providers must inform patients in a language they understand about their health status as noted earlier. An interview with Peter brought to light the situation that healthcare providers are facing in delivering equitable and effective maternal healthcare to migrant women making it a health governance issue:

> *MM: What are some of the local level factors that influence the access to public maternal health of migrant women?*
>
> *Nkosana: I think one of the challenges that one could be having that inadvertently makes access a little bit difficult I think it's the barrier in terms of some languages. You would have noted that most of our Primary health care clinics and even our government hospitals and I will not want to talk about private hospitals, but I also know private hospitals if you bring money even if you were speaking an Angelic language, they will attend to you, they will make sure that they understand what you are saying. But then, with us we provide service across, accessible and money is not supposed to be a pre-condition to access*

services. But then one of the things that we have noted is that, then we have particularly some of our African guys who are from the Franco areas where they speak French and when they come in they have this language barrier. Where you can see a woman is pregnant, you can see a woman is in labor but then they cannot talk. Until such a time when an escort comes and interacts, if there is no escort it becomes difficult and you will end up sometimes treating that person as if you are treating a machine that only has to convey a particular product, in this sense a child. ***(Interview: Nkosana)****.*

All the above quotes and sentiments on the issue of language barrier between the public healthcare providers and migrant women as a challenge to the provision of equitable and effective health care for migrant women were not exhaustive in this study. Effective communication between healthcare providers and patients is a core component of healthcare for it leads to collection of accurate history, proper diagnosis and prognosis (Paul & Shyde, 2007). In the absence of effective communication provision of healthcare ends or it rather proceeds but with errors, poor quality and risks to patient safety. The issue of language and culture has been raised in other studies that leads to migrants facing challenges in accessing healthcare (Makandwa, 2014; Moyo,2010). This study however discovered that healthcare providers also raised the same concern of communication between them and migrant women seeking maternal healthcare services which is a health governance issue influencing access to public maternal healthcare services of migrant women in Jeppestown. Third parties are often involved so as to assist with interpretation between the healthcare providers and migrant women breaching privacy as Thando notes:

Language is a very serious problem, also including privacy as we will involve interpreters of the language. Now you break the confidentiality between the nurse and the patient. There are some questions that you need to ask to a relevant person that does not need a third party. But, because of the language problem, now you need to involve a third party. Most of the time they don't come with their partners or family members. Those who are coming from far away they are just alone here, they don't have family members to give support. So that is another challenge that affect. Because some of the relevant information we don't get because they can't just, you know, disclose anything to a stranger. But if it's a nurse and a patient in a private place both of them, then the relevant information you can get ***(Interview: Thando).***

McIntyre et al, (2009) on access to health care framework emphasises on accessibility, affordability and accessibility where acceptability refers to the relationship between the healthcare provider and the patient in terms of attitudes and expectations, as these will influence the ability of individuals to receive care. The issue of linguistic barrier is linked to the notion of acceptability where there are differences in languages between healthcare providers and migrant women accessing maternal health which leads to them not receiving proper care or no care at all. This study adopted the health care framework as its theoretical framework and this framework helped in bringing out the issue of linguistic barrier as a health governance issue finding out that it is a challenge to the provision of

equitable and effective health care for migrant women. McIntyre et.al., (2009:180) coined a conceptual framework that explains and defines acceptability as a multi-facet concept that is grounded on the relationship between health care systems and individuals.

The following theme is an analysis of health budget where participants raised concerns on the increasing influx of healthcare seekers in the migrant dominated city which they believe to cause budgetary constraints on the health system.

4.4 High Influx of Migrants Affects Health System in terms of Budget Constraints

MM: Does migration affects health system in Johannesburg in terms of access and provision of healthcare?

Gugulethu: It does. It does because our facilities are expected to… (pauses) remember the constitution of South Africa says we cannot deny anybody access. It says so, everybody has the right to medical access. Now if the women are all coming to Johannesburg, let's focus on Johannesburg. They are all coming to Johannesburg, it has got a financial bearing. Remember we budget for a certain amount of people in the country but you find that (pauses). Maybe you must do a study on the buses that are coming specifically at Hilbrow. There are buses that come frequently, almost every week there is a bus that comes and bring women from outside the country. They come, they deliver and the following day the bus takes them back home. Mostly, they want the children to have the South African birth certificate and that gives them the right to automatically come this side. You know if people were doing things correctly, come with papers, I mean these are our brothers and sisters we can't deny them. If they could come with correct papers, then even with the census we would be able to budget for 4 million not budget for 2 million, yet we have 4 million in the province. That have financial constraints in the rendering of health system ***(Interview: Gugulethu).***

….we can have people that are coming from North West, migrating into Joburg which is the huge problem. Everybody wants to see themselves in Joburg and Joburg is not that big. So that is a problem hence initially ***(Gugulethu).***

Influx of migrants coming into Johannesburg is considered to be imposing a financial burden on the healthcare system as evidenced by the above interview with Gugulethu. This study found out that respondents raised issues of the high influx of migrants into Johannesburg for various reasons which has an effect of financial constraints in terms of budget in the rendering of health making it a health governance issue with some migrant women believed to be coming into the country for maternal healthcare purposes only. Healthcare providers and frontline staff complained on the issues of influx of migrants, yet migrants are entitled to access free healthcare through the National Health Act of

2003, but providers dwelled much on budget constraints implying that the health budget is meant for the locals. Johannesburg has been and still is a major destination for migrants across Africa and internally from different provinces within South Africa itself. Various factors push migrants to migrate to Johannesburg (eGoli) and amongst these factors is wars, political unrest, natural disasters, political persecution, serious poverty, hyper-inflationary trends and unemployment whilst pull factors to which migrants are responding include the relatively higher standards of living and the hope and promises of better job opportunities in Johannesburg. The high prevalence of migration (within the country and across borders) into Johannesburg is mainly in search of improved livelihoods opportunities with some migrating to seek health and help seeking including care seeking (Nunez et.al.,2010). Published literature indicates that both internal and external migrants tend to concentrate around the country's major cities with Johannesburg being a top migrant destination and new migrants arrive daily making it one of the fastest growing megacities in the world (Landau,2015; Vearey, 2014; Jean Pierre Misago et. al., 2010; Landau & Wa Kabwe Segatti,2009). Increasing numbers of women are now moving independently in search of livelihood opportunities since the end of Apartheid which had restrictive apartheid laws causing people not to move.

The above highlights how migration into Johannesburg reflects the heterogeneity of migration. This study even found out that more than half of the interviewed healthcare providers are internal migrants within South Africa with most of them originally from KZN. Most of the migrants especially the cross-border migrants end up engaging in informal livelihood activities because they would have faced challenges in accessing formal employment in the city and to this they often reside in the peripheries of the city that are detached from social services with most of them depending on the public healthcare since they do not have medical cover. Some end up being illegal migrants because documents will have expired in the process of trying to secure employment. Healthcare providers spoke on issues of budget implying that migrants are now competing with the locals who are budgeted for, causing a strain on the already overburdened and struggling public healthcare system. According to the National Health Budget of South Africa 2017/18, the National Department of Health oversees policy making, coordination and oversight of health services in the country while the nine provincial departments bear the primary duty of service delivery. In terms of financing, South Africa funds the bulk of its health expenditures from the nation's National Revenue Fund, but has also made strategic use of international aid, especially in supporting the battle against HIV/AIDS. Healthcare providers stated that the way the budget is designed is meant for the locals giving figures that the migrants accessing healthcare services contributes to shortage of resources which in the long run leads to budgets constraints of the National Health budget by trying to accommodate the migrants and the locals at the same time. An interview with Lebohang confirms this:

MM: Does migration affects health system in Johannesburg in terms of access and provision of healthcare?

Lebohang: You know what, I think it does because as people come in, with the stats that we have of people coming in…. L*et's say for instance the 25% are from Soweto and they moved to stay here in town. They belong to the city of Joburg those ones. I am talking of the other 75%. You know before clinics used not to be this full, we used to open two days even a day a week but now we have to run everyday even with the preventative, the booking, the family planning and the TB. Now we have to work every day because of the influx of the people coming from the homelands, coming from foreign countries. It affects the budget too because we budget for a certain number of population* ***(Interview: Lebohang).***

Lebohang's sentiments reflects how healthcare providers unfounded assumptions that healthcare budget is only meant for the locals implying that migrants are not catered for and causes financial constraints on the public health budget. This has consequential effects on migrants accessing public maternal healthcare as they are regarded as exhausting the resources of locals when it comes to healthcare provision. Lebohang's views also imply that external migrants are dominating more than the locals with an influx of those coming from foreign countries and the homelands to seek healthcare. The above findings are consistent with the existing substantial body of literature which states that there is limited governance and health systems capacity to respond to the issues of migration and health (Vearey,2011,2014,2016; Segatti & Landau,2011; Landau et.al,2011) where migration is always associated with health seeking, livelihood opportunities and that migrants are diseased people. Lebohang is of the notion that it is migration that has caused the overcrowding and workload in clinics and facilities. This according to Crush and Tawodzera (2014: 656) reflects one of the most common stereotypes that health services are being 'swamped' by non-nationals.

The healthcare providers concern on influx of migrants painted a picture which reflects that it is mainly cross-border migrant women who puts a heavy burden on the healthcare system yet in reality the reviewed literature and evidence states that the number of people migrating internally far outweighs the number of cross-border migrants in Johannesburg (Vearey, Modisenyane & Adams,2017). Landau (2005) states that migrants both internal and external migrants living in Johannesburg are seen as economic and physical threats even when they seek services such as public health they are usually denied access and has immediate and long-term consequences. The notion by healthcare providers of blaming the influx of migrants to be the cause of budget constrain on health system resonates their South African politicians and civil servants who have capitalised on the presence of migrants especially cross-border migrants to promote their own interests eluding blame for their own failings (Landau:2005). All these are unfounded simplistic assumptions related with political and scaremongering and the scapegoating of foreign nationals (AbouZar, Adjei & Kanchanachitra, 2007;

Vearey, Modisenyane & Adams,2017). This highlights politics of migration which has also been adopted by the street level bureaucrats where migrants are blamed for all the bad as Landau (2005) also notes in the reviewed literature that universal assumptions of non-nationals' criminality and threats to jobs and health have created a series of extra-legal and, often unconstitutional, practices oriented towards their control and eventual removal. The health minister publicly mentioned in an interview that South Africa's healthcare system is strained by refugees and migrants (The Citizen,2017). All these cases represent migrants as not belonging and being excluded from the polity and health delivery system of receiving countries and cities thus keeping them in obscurity as evidenced in the literature (Grove & Zwi, 2006, Agambeni, 1998).

> *The amount of money spent because each province is allocated a certain budget. Now, if someone migrates from there, that budget there is underused whereby this one is overused because there is too much people this side (Johannesburg) who migrate and come to this area. So, it affects that in terms of the budget. Remember the law says you can't chase a person away especially a pregnant woman. Once they enter a facility by the time they get out of the facility they must have that antenatal card. So that becomes a problem whether you like it or not you must attend. So, migration affects in terms of finance…….. medicine, you tend out to have stock outs now because you are distributing, distributing, distributing and those who are here who have been allocated they don't get* ***(Interview: Nomagugu).***

Nomagugu is also of the same view that migrant women accessing maternal health put a strain on the budget and finance of the health system and in the end, it disadvantages the locals who are budgeted for. Nomagugu's narrative is an epic situation of the presumed general association between migration and health in South Africa specifically in Johannesburg. The healthcare provider's notion on the influx of migrants having strains on health budget are also problematic because they imply that people migrate in order to seek healthcare and there is no valid evidence that shows that people move to seek health care. This study found out through governance of health issues that migration is indeed according to literature determinant of health as it interrelates with health outcomes and has an influence on health inequities in various ways and the issue of influx of migrant women being presumed to burden the health budget is an example and this undermines the developmental opportunities of migration.

A substantial body of reviewed literature states that the above scenarios and quotes reflect a lack of improved responses to the governance of both internal and cross-border migration in relation to public and population health including health system planning (Vearey, Modisenyane & Adams, 2017). It identifies a variety of mechanisms by which refugees, asylum seekers; irregular migrants and migrants in general are positioned as the 'other` and are defined and treated as separate, distant and disconnected from the host community by street level bureaucrats and those in authority (Grove &

Zwi,2006). Also, the media is to blame for inexorably reporting negatively about migrants and putting the blame on them for a wide variety of social and economic ills.

I will now go on to explore the theme on staffing and staff burnout which emerged as one of the major health governance issues influencing access to public maternal healthcare services of migrant women.

4.5 Staffing & Burnout

Another health governance issue that emerged was the theme of staffing and burnout. Published literature states that within the health care system, the nursing profession is the core of the health care provision in South Africa since they are at the frontline of healthcare. Maslach & Jackson (1982:3) defines burnout as "a multi-dimensional construct comprised of emotional exhaustion, depersonalization and diminished personal competence that occurs among those who do 'people work' of some kind". It normally occurs due to the widening gap between the individual and different demands of the job. It is believed that work-related factors such as shift work, workload, role clarity and ambiguity are revealed to be the principal causes of burnout among staff nurse. Healthcare providers revealed that staffing and staff burnout is a major health governance issues influencing access to public maternal healthcare services of migrant women. Participants had this to say:

> *Yah, obviously if you have greater volumes you know, you would have staffing issues, you would have infrastructure issues, you would have resource issues. Staffing issues there would be a lot of burnout because the staff can do so much with limited resources and then our infrastructure sometimes cannot hold all those great numbers* ***(Interview: Nkosana).***

> *……it affects in terms of the burnout for staff, you get a burnout because you are attending too many people* ***(Interview: Nomagugu).***

> *So you find that the number of staff does not really match the number of patients. You see, one sister has to book more than 10 patients or see 10 patients for that matter, at times it doesn't become ideal because this sister is rushing to make sure that at least let me push. Then there are things that will be missed on the way or one patient will be missed. If we had time, if we were given that time to say you see a pregnant patient for an hour with a professional nurse but we can't because we are rushed because of the numbers of the patients so we end up not giving that much quality because of the numbers of patients as opposed to the number of professional nurses* ***(Interview: Lebohang).***

The above quotes from the healthcare providers gives evidence that staffing is one of the major health governance issues influencing access to public maternal healthcare services of migrant women. This study found out that within the past two decades, the South African healthcare system has been through a revamp process that was aimed at the implementation of an all-inclusive primary health care system. With these progressive changes healthcare facilities have turned out to be so demanding

and stressful work environments for healthcare providers and frontline staff and this affects employee well-being and organisational goals, yet globally health-care systems are challenged to provide quality care to the population of the world and South Africa is no different. Many health care providers are not adapting with work-related demands due to the shortage of staff, lack of resources in healthcare facilities, unrealistic workload due to influx of patients and burnout which has seriously impacted on patient care and employee productivity. Various scholars state that a central challenge of the health system has been an unwillingness to strengthen management of human resources (Coovadia et. al.,2009). The shortage of staff and burnout has resulted in compromising the ability to deliver vital programmes such as child health and maternal health especially for migrant women accessing public maternal health. Respondents dwelled much on the issue of workload which resulted from shortage of staff and this leads to the healthcare providers taking out their staffing and burnout frustrations on the patients, in this case migrant women accessing maternal health. The study also found out that the shortage of staff is also due to an acute shortage of training, support and supervision, with reliance on student nurses working under minimum supervision or no supervision at all. All these have led to job dissatisfaction amongst the healthcare providers.

Robinson & Clark (2006) laments that health professionals are essential to healthcare delivery because they are the health system's life blood. It is sensible in this manner that the quality debate consolidates the health care providers voice and considers wellbeing delivery impact on health care providers, especially when the impact is negative. The issue of staffing and burnout leads to the health care providers developing negative self-concepts and job attitudes and a reduced concern for patients (Robinson & Clark, 2006). The result is that migrant women accessing public maternal health will face challenges when healthcare providers portray negative attitudes towards them by being rude and shouting at them due to issues of staffing and burnout. Nombuso confirms this scenario as she narrates in an interview:

> *I think the challenges that we have at the moment is a huge shortage of health professionals and shortage of staff. Staff shortage is a huge problem in our clinics. The other one is uhmmm its workload, we have high volume of patients that are visiting our facilities and we are not coping with the numbers that are coming because remember its shortage plus huge high number of high volume of patients that are visiting us…Because sometimes they can be this rude because of shortage of staff but they can't tell the patient that they are short-staffed. Because of that they get irritable, and sometimes they don't talk nicely with the patient, but if you go deeper and interview a nurse you will find that she was saying that because they were short-staffed now she was talking rude to patient and a patient is not responsible for that situation. You understand* ***(Interview: Nombuso).***

From the above, it is self-evident that delivery of high quality care in health care facilities is compromised due to the shortage of staff, high workload and burnout which results in healthcare providers inability to provide the best care and this is a clear violation of the health system. Health system according to the substantial literature reviewed is defined by the WHO Report (2000), functionally as "all the activities whose primary purpose is to promote, restore or to maintain health". In addition, according to the literature reviewed, the WHO (2014) outlined a plan of action for world health systems and governance that stipulates that moving closer towards governance of health requires amongst others the needed health services to be available, of good quality and affordable which in turn requires attention to all the various components of a health system including infrastructure, medicines and medical products, health workers, health information and health systems financing. To this the issue of staffing is a major health governance issue and if not addressed leads to health care delivery being seriously compromised thus affecting those seeking it.

Due to the shortage of staff, the study also found out that pensioners and retired health care professionals are being hired back into the health sector. Student nurses are also part of the equation in the health care facilities and most of them work with no supervision. Mary, a retired nurse had this to say:

> *I am actually a pensioner, neh. I went on pension in 2013, so I only came back last year (2017) to come and assist because of shortage of staff* ***(Interview: Mary).***

> *"Health care facilities mainly depend on the student nurses now, the reason being that there is a serious shortage of health care professionals in public clinics and hospitals. Most of the qualified nurses left the country for greener pastures and some have joined the private sector, clinics and hospitals. So, it is a struggle in terms of staff in the facilities". (field notes, 14/03/18)*

In line with the above quotes on staffing, the reasons for the shortage of healthcare providers and professionals are varied and complex with most of the providers pointing out to an unhealthy practise environment (Bauman, 2007) especially in the public health care sector. Reviewed substantial literature states that significant features of primary health care are not in place and there is a substantial human resources crisis confronting the health sector (Vearey et.al,2010; Coovadia et.al,2009). Crush and Tawodzera (2014) laments that South African public healthcare facilities are understaffed, with healthcare providers highly stressed and overworked. Most of the health care professionals have left the public sector due to job dissatisfaction and discouraging wages and some have left because of opportunities for advancement. Substantial body of literature and studies confirms that in South Africa's shortage of healthcare professionals is due to a plethora of factors and among them is dissatisfaction, linked to remuneration issues, poor working conditions, lack of

resources in facilities, opportunities for advancement and unfavourable organisational climate or environment (Coovadia et.al, 2009; Pillay, 2009; Moola et. al,2008). The working environment can also contribute to the issue of staffing for it is a determining factor which lures staff to stay on the job or leave. In the healthcare sector working environment is called practice environment (Shirey, 2006) which refers to the physical, social and psychological characteristics of a working environment. For healthcare providers and professionals to stay on their job the practice environment has to be a healthy practice environment which Shirey (2006) defines as a work setting in which policies, procedures and systems are designed in an all-inclusive manner so that the staff is able to meet organisational objectives and achieve personal satisfaction in their work. All this links back to health governance and governance of health frameworks and such issues in health governance if not followed leads to the negative experiences and factors that influence migrant women in accessing public maternal health. This leads to the next emerging theme which explores the initiation of ANC and this study considered it to be amongst the major governance of health issue influencing access of maternal health to healthcare users.

4.6 Initiation of ANC: A governance of maternal health concern

The South African Department of Maternal Health Guidelines (2007:20) expresses that Antenatal Care (ANC) should commence at a woman's first visit to the clinic, even if the first visit was merely to confirm pregnancy. Antenatal care is concerned for the most part with prevention, early diagnosis and treatment of general medical and pregnancy associated disorders. According to Hoque, Hoque and Kader (2008:66), "ANC *is provided in accordance with National protocols and guidelines at all public health care facilities in South Africa*". The WHO made recommendations that on average any pregnant woman must visit antenatal clinic for a minimum number of four times (WHO,2006:1). Pregnant women with late initiation of ANC have higher chances of attaining poor outcomes of pregnancy. The WHO (2015) estimated that 138 women per 100 000 live births in South Africa die because of pregnancy and child related reasons. These women die preventable deaths during and due to pregnancy and childbirth due to various reasons and among them is late booking in antenatal care (ANC) and not booking for ANC (unbooked cases) which will be discussed as a sub-theme emanating from the initiation of ANC. The healthcare providers also raised concerns that some women simply do not follow up with their ANC visits. This study found out that late booking and unbooked cases in ANC is one of the major health governance issues influencing access to public maternal healthcare services of migrant women. Late booking or late attendance is attending antenatal care or going for maternal health services to the clinic for the first time after 20 weeks (5 months) of pregnancy (National

Department of Health, 2013) and it is considered as one of the causes of high maternal mortality in the country. This led to the following sub-theme of late booking and unbooked cases in ANC.

4.6.1 Late Booking & "Unbooked" Cases in ANC

Various reasons and issues came up that causes late booking and unbooked cases in ANC during this study among them were fear of HIV testing since it is administered as part of the routine during ANC, avoiding waiting in the long queues at the clinics and fear of negative treatment by healthcare providers making it difficult to value ANC visits among others. The study also found out that some migrant women only come into the country for the purposes of delivering and then they leave the country soon after delivery which is also a health risk that contributes to maternal mortality. The study also found out that other women delay coming to register for maternity and only come when they are just about to deliver with some migrant women taking traditional herbal concussions acquired from their social networks popularly known as "Isihlambiso" which precipitates labor and in the long run these affect both the mother and the child. All these factors are issues of health governance which affects the pace of ANC booking. Lebohang had this to say:

> *Late booking that is the first one and I think one of the challenges. Booking after 12 weeks, at 3 months. Ideally, we want them to book before 12 weeks or at least before 20 weeks but you find that others come just before the month before they deliver. I don't know. You know what (pauses) I wouldn't know. But from what we hear from patients they will say its attitude. I don't necessarily know what are the problems. Beside them saying its staff attitudes that prevent them from coming. I would turn it around and say it's their attitude also. You know they think for people before they even go. Somebody will say they will say I am old, I am 38 years and I am pregnant, others will say I am too young. But you will get your ladies that are around 22 years they do come because we all think they are acceptable. They come freely and yah. So, yah I think mostly its staff attitude and with the other people I think its ignorance. They don't come because they think what's the point of going because I am not sick I will go only when I am ready and when I see that I am pregnant. With others it's the issue of just generally being scared of testing for HIV because we advise all women to test for HIV. We don't force them, we advise them, and we would love for them to test. It's very rare that you find that in any of the clinics that you will get a woman that refuses to test. Others will say I won't go until I deliver once the baby is here what will be the use. Because it's a continual thing and we will still offer the test and say can we please test you because we want to know your status and the baby so that we protect the baby. So, I think its necessarily ignorance, attitude and just fear of the unknown. Fear of they will go and test me and I might find that I am positive. So, what, because if you are positive will treat and if you are negative will teach you to remain negative. Another thing, just to add, another problem is the queues you know, because there is a lot of work that you do with the pregnant women. You find that sometimes a person will say the last time I went there I sat the whole day there. But we teach them when they book to say when you come please bring yourself some*

juice, water and something to eat because it might take long. It's not a matter of saying hi, how are you, your name and they go. No, we have to take the whole history to be able to take the whole history help them. So, shame they do sit for long especially when they book. It's better on follow ups. But for the first time they do sit for long and because in most clinics you find that there Is one professional nurse that's doing the booking so they will sit for long ***(Interview: Lebohang).***

Lebohang's experience with maternal healthcare shows that the issue of late booking and not booking for ANC is a serious cause for concern as far as health governance of maternal health is concerned especially for migrant women accessing maternal healthcare in Johannesburg as this is a migrant dominated city. Late booking and unbooked cases in ANC has led to the factors influencing access for migrant women. Late booking is a significant risk for maternal mortality and South Africa has one of the highest maternal mortality rates and migrant women contribute to the South African population. From the quote it is implied that most migrant women are reluctant to go for ANC initiation because of the healthcare providers attitudes towards them however, from Lebohang's response she notes that it is actually the migrant women's attitudes due to their pre-conceived mindsets of healthcare providers, this then results in them experiencing challenges in accessing maternal healthcare. Lebohang also states that though staff attitudes towards the migrant women contributes to them to delay initiation for ANC, migrant women are just ignorant and turn a blind eye when it comes to ANC booking. Some migrant women are ashamed to initiate for ANC because of their age they feel they are too old to be pregnant and to this they are ashamed to attend ANC visits and only make the move just when they are about to deliver this then affects the pace of ANC booking making it a health governance issue.

Fear of HIV testing during ANC is another contributing factor that hinders most migrant women not to initiate ANC as it will add more stress if they were to find out that they are positive as Lebohang noted. It shows that regardless of the intense HIV/AIDS programmes and education and fight against HIV campaigns and voluntary testing in South Africa and all over the African region, people are still reluctant to go and test for HIV and this study also discovered this. Various studies have been conducted that shows why women, not just migrant women fear to initiate for ANC and most of them found out that one of the reasons was the fear of HIV testing (Govender,2016; Pell et.al.,2013). Also, the issue of long queues at the healthcare facilities were said to be demotivating for most migrant women to initiate ANC leading to delay in accessing ANC.

Another factor that was repeatedly expressed by healthcare providers was migrants who come to healthcare facilities on the eve of delivery, yet they have never registered or attended ANC, making it a health governance issue which influences access to maternal health of migrant women. Some of the

women are said to have come from the neighbouring countries that very day only for delivery purposes. Gugulethu notes:

> *Maternal healthcare challenges that we see, we have a lot of migrant women who would come in the country or in the province on the eve of their delivery. They didn't attend antenatal care clinics, so we couldn't pick up whatever challenges.* ***(Interview: Gugulethu)***

Nkosana also raised the same concern:

> *Who would have thought that we were going to have 2 to 3 buses that are coming in almost weekly, that are coming from Zimbabwe coming to access health services here at Hilbrow?* ***(Interview: Nkosana)***

Gugulethu and Nkosana's sentiments indicates that unbooked cases are a serious challenge as migrant women come into the country for delivery purposes only yet the healthcare providers do not eve have their history and this does not only put their health and lives in danger but also hinder quality delivery of health as healthcare providers might not deliver the best of care without having the migrant women's history because they just jet into the country on the eve of delivery. Gugulethu further sadly highlighted that:

> *Unbooked cases. They are giving us such a challenge. We can't pick up problems on time. They will come when they are due for delivery. Sometimes the person is having hyper-tension, sometimes it's a previous Caesar and we can't just deliver you like that. At the clinics we have something that we call in Midwifery, "trial of a scar" meaning when you had Caesar with your first baby, during your second pregnancy in hospital they can try and put you to see if you can deliver normally with your second baby. But in clinics, it's a risk that we cannot take. Once a woman had a previous Caesar whether it's once or twice, we refer them to the hospital. So sometimes a person delivers with a Caesarean somewhere wherever and then with the second baby they feel that they want to deliver their child normally. They are forgetting that it's not because you wanted or doctors just needed to do the procedure. There is an indication why we do Caesar. So, they don't have that information. And they will stay wherever they are staying and then they would come on the 11th hour when they can't now bear the pain of delivery then they would come to the hospital. So, sometimes you find that the person starts to fit because of high blood pressure that is not controlled, sometimes you see a person starts bleeding, abnormal bleeding which is due to a lot of factors, sometimes they bleed to death. Sometimes we have raptured uterus' which forces us to take out the uterus, you lose your first child. So that is the danger of not attending ANC. Sometimes this Isihlambiso thing has impacts on the child, you may deliver the child but you may deliver a child that is already affected on the uterus and after some years you have realised that this child is not okay then you come back and say the department of Health you owe me. It's some of the things that are done by the women without having enough information and when they are offered that information through ANC, they don't come for ANC, they only come for delivery. So those are the challenges.* ***(Interview: Gugulethu).***

Gugulethu states with concern that some migrant women avoid coming for ANC and only come when they are due for delivery because they fear that they will be delivered through Caesarean Section (C-section). Most of the women giving birth do not prefer the C-section and they prefer the normal birth so to this they have pre-conceived mind-sets that if they go to the hospital or maternal clinics on the eve of delivery they will deliver normally. Gugulethu laments that this is a serious challenge they are facing as healthcare providers for it has caused many fatalities in the maternal health department.

In addition, migrant women are believed to be taking traditional medicine acquired from their social networks which precipitates labor and this traditional medicine is affecting women during childbirth as also noted below:

> *…….. you know Africans are Africans and am not saying South Africans, I mean Africans in general. They have their own way of doing things, they have their own traditions. There is this tendency of taking something they call "Isihlambiso" (concussion that precipitates labor) all countries prepare a different concussion of Isihlambiso. Isihlambiso is something that precipitates labor. So, you find women taking that and in their minds they are trying to say when we get to the hospital we want to deliver and come back. Meanwhile there are challenges of the womb that has not been ready to open up and you start this artificial contraction and you know we have something that we call induction. We have inductions that is done properly with tablets and when they do it in clinics or hospitals, they will put a tablet, a certain amount. But, when they put their Isihlambiso, they just take anyhow no measurements or nothing and you can imagine if the womb was just closed and not yet ready to open and you start contracting it, it ends up with very fatal results. Whereby you find it was so precipitated that we lose the child at the end of the day (number 1), (number 2) you find that the woman loses her uterus because of this induced labor that was not done properly with correct medication if I may say. (**Interview: Gugulethu)***

The above scenarios explained by the participants represents how maternal health especially ANC is very crucial in the life of a pregnant woman. Migrants fear to initiate for ANC due to the wide and complex factors mentioned above and in the end the country faces high maternal mortality rates, and this is a serious health governance issue which in the long run influences access to maternal health of migrant women.

However, with the valid evidence and sentiments from the healthcare providers on the notion of late booking and unbooked cases one can also argue that migrants are not entirely to blame for the late initiation and unbooked cases of ANC. The is a lack of health education by the South African health department is also to blame for the late initiation and unbooked cases of ANC. Health education is defined by WHO (2013:20) as, *"any combination of learning experience designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes."* There is need to strengthen health education initiatives on the benefits of ANC initiation among

women especially migrant women accessing maternal health in Johannesburg as this will be part of an approach to address the current maternal mortality concern. This is in line with governance of health as the WHO (2012:vi), define governance for health and well-being as, "the attempts of governments and other actors to steer communities, whole countries or even groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches".

Lastly migrant women especially cross border migrants avoid initiation of ANC because of they are afraid of being asked for documentation when they report for services. Most migrant women do not have proper documentation or documentation at all and most of them reside on the peripheries of the city and they enter into the country illegally with some using expired documents. The National Health Act (2003) states that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities regardless of nationality, documentation and residence status yet migrant women are constantly asked to produce documentation and give their residential address when they visit healthcare facilities for ANC and maternal health related services. The policy directives are forever flouted in public hospitals and clinics. This then makes most migrant women to be reluctant to initiate ANC because most do not have documentation. Crush & Tawodzera (2014:661) state that, *"Migrants without identity documents tend to regard clinics and hospitals as spaces to fear rather than seek relief."* The issue of documentation is a contested issue around facilities even in South Africa in terms of access to social services and resources including access to health. Migrant women face challenges with the police and the immigration officers regarding documentation in the city and to this they also associate the healthcare system to be of similar traits and they end up living imaginary lives in fear of the need to have documentation when they access healthcare services. However, in the absence of authorized directives to the contrary the healthcare providers end up abusing their positions when migrants come for healthcare services as they have power to withhold services influencing the way in which those services are rendered (Crush &Tawodzera,2014:656) which then leads to migrant women to be reluctant to initiate for ANC. The Human Rights Watch (2009) even noted with concern that the healthcare providers in South Africa are putting the lives of the country's large foreign population by denying health care and treatment to migrants, refugees and asylum seekers.

The following section is a comparative of internal healthcare seekers versus the external healthcare seekers' experiences in accessing maternal healthcare.

4.7 Comparative of internal migrants versus external migrant women's experiences in accessing Maternal healthcare

This section will give a brief comparative overview between internal migrant women in accessing public maternal health a bid to understand whether these experiences differ or are similar from those of cross border migrants. This is based on the women's narratives on their experiences in healthcare facilities, with healthcare providers or the general accessing of public maternal healthcare. The comparative will be based looking at factors such as communication between the healthcare providers and the migrant women, attitudes of healthcare providers towards the migrant women, experiences during after pregnancy amongst others. All the interviews for both the internal and external migrant women were conducted at Jeppe clinic during their ANC visits. The first comparative will first explore the experiences in communication.

4.7.1 Communication

I: In terms of communication, seeing that you're Xhosa speaking, would you say it is harder to communicate in Xhosa with some nurses who speak a different language? Have you ever experienced any language barriers?

P: No because I feel like here, what is spoken a lot whether you're Venda or what, but the common language here is isiZulu. So, I mean it can't be a language barrier because there's not much difference between Xhosa and Zulu so I don't face any challenges in terms of language ***(Interview: Yoliswa) (Internal Migrant from Eastern Cape, Mzimkhulu)***

I: Would you say again that language is a problem?

P: No, they speak well even if you don't understand Zulu

I: They explain? And would you say maybe you will if you were to get the child at North West, you would be compelled to speak the language from there?

P: What can I say? Where I'm from I'm Tshwana and I came here (Johannesburg) I can speak Zulu even now I live with a Zulu. So, I can mix Tshwana and Zulu, I'm already used to speaking Zulu. It's difficult when I'm at home speaking Tshwana because full time I speak Zulu here. So, with the nurses I can speak Tshwana or Zulu and they understand me well, so it's not a problem. ***(Interview: Sandra) (Internal Migrant from North West)***

With internal migrants it is better than outside migrants. Whether you are Venda, Shangani or whatever we can talk and understand each other ***(Interview: Lerato). (Healthcare Provider).***

From the above narratives of the internal migrant women (Yoliswa and Sandra) it shows that, consistent with the provision of many, if not all health services, communication is key to building a healthy relationship and it is very essential for equitable and effective health delivery. From the study, it was evident that most if not all internal migrant women do not experience any communication difficulties with healthcare providers when accessing healthcare services as Lerato the healthcare provider noted. As mentioned earlier on, South Africa has eleven official languages and numerous non-official languages (Deumert, 2010) with a diverse of ethnic groups and culture especially in Johannesburg. The popular and most common home language that is mainly used in Johannesburg by the locals is Zulu. From the above it is evident that regardless of the Province where one originates from within South Africa, it is easy to communicate with a Zulu speaking person even if you are not Zulu and this makes it easy for internal migrant women to interact with healthcare providers in the healthcare facilities making it easy for them to access healthcare services thus building healthy relationships with healthcare providers.

Interviewed internal migrant women from this study confirmed that since South Africa has eleven official languages and if one can speak at least one or two of the South African official languages then it is not a challenge communicating with anyone who comes from any of the nine South African provinces. This study found out another factor that as long as one is South African and is an official speaker of the eleven official languages, access to healthcare is not a challenge, for the healthcare providers are welcoming to their own people. The public health sector itself from the clinics to the hospital facilities are dominated with internal migrants from different Provinces of South Africa so internal migrant women accessing maternal healthcare rarely face challenges in terms of communication because chances of them finding a healthcare provider who comes from their Province are always high and in most cases, they end up speaking in their language from their Province.

However, this was not the same with cross-border migrant women interviewed in this study. Since the study was also concerned with understanding the experiences of internal migrant women in accessing public maternal health and whether these experiences differ from those of cross border migrant women experiences, it was necessary to interview both the internal and external (cross-border) migrant women. External migrant women interviewed concerning their experiences in connection with communication between them and healthcare providers when accessing maternal healthcare had this to say:

I: Did you have any communication problems with healthcare service providers?

P: Yes. The main problem is language. Me I am staying in Bez Valley, but I can't go to Bezvalley Clinic I come here at Jeppe clinic. So, I can't go there because they speak only Zulu at the clinic and me I can't understand Zulu. My first pregnancy I went to Bez Valley, I had a difficult time even where I went for maternity to deliver at Leratong Hospital it was the same thing. They left me alone when they find out that I was speaking in English saying I am not a white man or Indian to speak English to them and they left me there. …. So, I was always worried when it came to visiting the clinic in Bez Valley because of language ***(Interview: Chimwala) (Tanzanian Migrant)***

I: Do you have any communication problems with healthcare providers?

P: I stay in Malvern and I have since stopped going to Malvern Clinic or Julies clinic and I prefer coming to Jeppe Clinic. In Malvern and Julies the nurses are rude and do not want to speak in English they are so anti-foreigners that's why I now come to Jeppe because the nurses here are nice and speak to us in English. ***(Interview: Tanyaradzwa) (Zimbabwean Migrant)***

The above cross-border migrant's sentiments on communication difficulties when accessing maternal healthcare in the public facilities highlights how there is a deep resentment amongst the healthcare providers in using English when foreign migrants visit healthcare facilities. In a similar study carried out by Makandwa (2014) on experiences of non-nationals accessing maternal healthcare in the inner city of Johannesburg, language was the found to be the major challenge in accessing healthcare services by the non-national migrant women. External migrants are constantly discriminated in healthcare facilities because of the issue of language as evidenced by Chimwala and Tafadzwa's experiences in accessing maternal healthcare services. The reason why migrant women end up frequently changing facilities around the inner-city of Johannesburg is because they will be opting to go where they get better, migrant friendly services and in this instance language is normally a consideration. Vearey (2011) is of the view that migrants especially international migrants accessing healthcare services struggle to access healthcare because of the communication barrier between them and the healthcare providers. The quotes from cross-border migrants shows that there is deep hostility in most of the public healthcare facilities towards external migrants compared to internal migrants and this makes the public health care facilities in Johannesburg to be migrant-unfriendly health facilities.

The quotes from the cross-border migrants portrays xenophobic tendencies by healthcare providers and stereotyping attitudes towards cross-border migrants which according to Crush and Tawodzera (2014:657) is a central phenomenon of 'medical xenophobia' in the public health system. Where they define medical xenophobia as, "*the negative attitudes and practices of health professionals and employees towards migrants and refugees based purely on their identity as non-South African" (pg.655)*. One can clearly note that from this study, the comparative of internal migrant women versus

external migrants, experiences of the two in terms of communication are totally opposite as internal migrant women are more favoured by healthcare providers when accessing public maternal health simply because they are South African and that they can get along with local languages and they relate easily simply because they are South African and providers feel that they have a right to access healthcare services as compared to external migrant women who are discriminated because of language and their identity that they are non-South African. This according to Andersen (2004) shows a differential treatment of patients by healthcare providers and this is a huge hindrance in the realisation of equity in healthcare. The next section is a comparative of experiences during and after giving birth.

4.7.2 Experiences During Giving Birth

This study further went on to compare experiences of internal migrant women versus those of external migrant women during the process of giving birth and how they were treated. It also made a comparison during ANC.

I: Where did you deliver your first child and if you can take me through the experience?

P: I got her here at Hillbrow. With everything they would tell you with check-ups and all. They were open about everything if you had to get an injection or anything they would tell you this is for this and this is for that. So, if your child has to come for a check-up it's for this. If your child has to get certain vitamins it's for that. They're open about everything and very nice at the same time. So, if you have a problem you'd ask a question and they would tell you. The experience was very good I never encountered any problems even with the nurses, they were helpful ***(Interview: Rendani) (Internal Migrant from Limpopo).***

I: Okay maybe would tell me about your experiences about antenatal. Your experiences so far since you're attending sessions in Joburg maybe you can start with Joburg specifically and then your background of your experiences with your first child?

P: Well here at Jeppe they have excellent service when I compare it what was in Eastern Cape. There I think the nurses are nicer here, they take tests I didn't take with my first pregnancy like blood tests. They check everything. There because I got pregnant when I was still in varsity, so I had to attend in East London when I gave birth I went to PE, but essentially in East London their service I'm not saying its poor but it wasn't as excellent as the service here.

I: Okay and then maybe what services that you received here that you didn't get there so just specific services that you got?

P: Okay when I was there I think it was donkey years ago. When I was there first of all when you go to a clinic, when I came here I just told them it's my first time and I didn't know what to do. Like this is the same thing, same process. But when I came here they just told me to sit on the side so that they can test

my HIV test. I think it's just that and then they told me of the date of which I had to come back. In East London when I went there for the first time they just gave me the run around. Like I'm saying when you get there you don't know what to expect, you don't know what to do. So, they just give you the run around. They start helping other people I would say that know than you. Then they help you later on when they're done with other people. Here when I came here for the second time we sat they explained everything….. Like I didn't know all of this information they explained everything here. They explained how to check yourself, how to check your partner. How to be safe for the baby but there we didn't get those lessons. This thing of getting counselling before you get HIV testing I didn't get that. Here I got. Yeah and then there's this SMS thing (MoMConnect) I forgot the name they just tell you every day, how to eat, what not to eat when you're pregnant, how much water you should take and all those things. So basically, here they are caring so you see I moved to Brakpan but I still come here to Jeppe because they're more caring. They really have good service. ***(Interview: Sandra) (Internal Migrant from North West)***

Sandra and Rendani, internal migrant women narrates their experiences in giving birth and accessing ANC in Johannesburg public healthcare facilities. The two quotes above reflects that for internal migrant women, experiences in accessing maternal health care until the time of giving birth in Johannesburg is a breath of fresh air to them as compared to their Provinces of origin where most migrate from their homelands that have less better facilities in search of better livelihoods opportunities and services compared to Johannesburg health facilities which is a far much bigger city with better and advanced facilities and services. The interviews reflected that most if not all migrant women migrated from areas where resources are poorly allocated. In most parts of the rural South Africa, accessing good quality and comprehensive health care remains a challenge and resources are poorly allocated (Gaede & Versteeg, 2011). While space is inadequate to make a comparison of health outcomes between Johannesburg and rural South Africa and other Provinces within South Africa, the consensus is that the levels of deprivation in rural and remote areas of South Africa there is insufficient attention given to the social determinants of health in uplifting the health of rural communities (Gaede & Vesteeg, 2011:101). Sandra confirmed that her experience in accessing public maternal health in Eastern Cape before she migrated to Johannesburg was not as excellent as what she is experiencing in the Johannesburg public health facilities. Rendani also expressed contentment with her experience when giving birth stating that the healthcare providers were helpful and took her through the whole process during and after pregnancy.

Rendani and Sandra's experiences are however not the same with cross-border migrants who participated in this study. A classic emblematic quote below from Esther regarding her experience of giving birth is used, and she had this to say:

I: Can you please take me through your experiences with antenatal care in healthcare facilities you have used up to the time you gave birth here in Johannesburg?

P: Hilbrow is not good at all. Most nurses there are student nurses and when you get there during labor they count certain hours and after that they operate you (Caesarean) and the nurses are rough, and they were shouting at me when I gave birth. That is what they did to me. They should have given me my time in labor trying to push the child out not rushing to operate me. So, with this pregnancy I have, my friends are encouraging me to go and deliver in Germiston they say services there and the nurses are good. They say at Germiston they don't rush to operate(Caesarean) you unlike Hilbrow they rushed to operate me, and they were very rough and shouted at me in their language. So, in Germiston the problem they say if you arrive there they do not give you a bed at once, but they make you sit in a chair and then allocate you a bed later when you are about to deliver whereas in Hilbrow they give you a bed and rush to operate you (Caesarean) and they are rough. ***(Interview: Esther) (External Migrant from Zimbabwe)***

Esther's sentiments reflect how the public healthcare system is impaired. Comparing with the previous quotes from internal migrant women experiences, this study found out that external migrant women face ill-treatment during pregnancy up until delivery. Vearey (2009:361) states that while South Africa has a shielding, integrative, urban migrant and refugee policy, many of these characters struggle to access the rights to which they are entitled, including healthcare and their stay in the city becomes unbearable. This is the case with Esther, a Zimbabwean migrant woman who has now opted to find alternatives from her social networks of where she is going to deliver her next child within the city due to the struggle and negative experience she had when giving birth and accessing maternal healthcare at Hilbrow. Esther's case is not the only one as all interviewed external migrant women had their nasty experiences to tell. The experiences of both internal migrant women and those of external migrant women in accessing public maternal health are clearly not the same. Crush et.al. (2005b) argues that paramount to understanding migration and health is the need to identify social complex challenges of different migrant groups within spaces of vulnerability that is associated with migration. Esther's narrative is in agreement with Abraham, Jewkes & Mvo's (2001) notion that healthcare providers in public sector are described as using humiliation and verbal abuse to assert their authority over patients. This study found out that internal migrant's experiences in accessing public maternal health in the migrant dominated city of Johannesburg are way better off than those of cross border migrant women and their experiences differ. Following is a comparative on waiting periods in facilities.

4.7.3 Waiting Periods in Facilities

This study found out that all the migrant women both internal and external bemoaned the long patient waiting periods during their ANC visits to the clinic. Lengthy waiting times are a major disappointment for patients attending public healthcare facilities. According to the SA National Department of Health (NDoH), (2015) patient waiting time is the amount of time a patient spends waiting for services in a health facility from the time they enter the facility. Both internal and external migrant women

complained that clinic visits are lengthy, and it leads to most of them hesitating to come for ANC with most cross-border migrants moving from one clinic to the other to avoid lengthy waiting periods. Others complained of the clinic opening times with some attending post-natal care raising concern that it is not healthy to wait in the long queues with newly born babies who are barely three days old.

> *The queue you see I think people are waiting there. It's that queue I think the clinic should start at seven. Isn't they say it starts at half past seven? These people should start at seven with registering people so that at least by half past seven some people are inside and then someone can start with certain people. Like if you bring your child here let's say it's for immunisation I don't think any parent wants to spend three hours. First you spend one hour outside with your child and then you will spend three hours inside with your child because the queue is very long so that's why I would recommend that I think they should start at seven because by the time they start, after one (1 o'clock) their work is finished. So, they should start at seven because after one their work is finished they're no longer registering people. So, if they start earlier and then at one o' clock they can knock off it makes it easier because the mothers that are waiting here, imagine you're standing outside and you have a baby who is three days old. Like three, before you were in labour and three days afterwards you're standing in a queue and that person will start later. At least if they can start registering earlier even if they don't open but when they start then by opening time they'll know this is the amount they had, and they can start with the rest.* ***(Interview: Snobani) (internal Migrant from KZN).***

Snobani, an internal migrant woman spoke on the prolonged waiting times in the clinic during her maternal care visits suggesting that the facilities should consider opening early to ease the lengthy waiting periods when accessing maternal healthcare services in the clinics. She laments that they should open earlier than 7:30 am since they close at 1pm and much of the time the women will be waiting in the long queues to access services. Snobani poured her heart out on the lengthy waiting period stating that it is not realistic to wait in the lengthy queues with her three-day old baby raising concern that she had given birth three days back and expected to wait lengthy queues again for maternal healthcare services. Another internal migrant woman had this to say about the waiting periods:

> *I: In terms of ANC registration periods, like when you have to be filling out forms and doing all that would you say it's a process that takes a long time?*
>
> *P: I would say as I'm here with you I'm number six, but I will go back to find the line stuck. It's just a long thing. Especially here at public clinics it's not like with private doctors. Private doctors check lines as they're concerned with money and time but here in the clinic no as many as we are we are all done by one person….Yes, whereas with a private doctor I would have gone in and left so yeah it's just money.* ***(Interview: Thokozani,) (Internal Migrant from Eastern Cape, PE)***

The quotes from both internal migrant women shows that they also experience lengthy waiting periods in clinics and all the interviewed women raised concerns over this. Long waiting times delay every stage of visit and in most times, they frustrate the patients to leave before they are attended to (Guttmann et.al,2011). Thokozani shows a lot of dissatisfaction with the services from public facilities in terms of the waiting periods and would rather opt for a private doctor if she had the money. Some scholars associate the lengthy waiting periods in the public health facilities with the lack of capacity to meet patients demand (Silvester et.al,2004). Another migrant woman attending post-natal care had this to say:

> *…. I feel like, like here I got here a long time ago. I got here at half past seven and we were standing in a long queue and I feel as though like you're told with children after giving birth you should bring them back after three days. Standing there with a new born baby I don't feel like it's healthy in any way because that baby will now get sick from that cold.* ***(Interview: Yoliswa,) (Internal Migrant from Eastern Cape,PE)***

All the above quotes on experiences regarding lengthy waiting periods from the internal migrant women were no different from those of cross border migrant women. Migrant women also beamoned the long waiting periods when attending maternal healthcare services at the clinics. They had this to say:

> *The queues here are long and we wait for long before the nurses attend to us. I have to wake up early around 4am and get here at 5am and I queue with the others waiting for the nurses to arrive and serve us. If you get here early you will leave late sometimes you won't even be served by the nurses if you are late by the time they close even if you are in the queue they will tell you to come the next visit yet you will be waiting all this time…. We come early, and we stay outside for long and it's cold, winter time and you have a child on your back. They should also open early because we wait for long here and the queues are too much.* ***(Interview: Amidah) (External Migrant from Tanzania).***

Amidah's sentiments on lengthy waiting periods shows that both internal and external migrant women experience the same when accessing maternal health. From the comparison of waiting periods in the facilities, it shows that it affects the utilisation and access of maternal healthcare by the migrant women as it demotivates them to attend ANC and maternal health care services which is considered as a barrier to health services. From the comparison both migrants beamoned the lengthy waiting periods that they both experience when the visit the clinic showing a similarity in experiences faced when accessing maternal healthcare.

4.8 Chapter Summary

This chapter provided a comprehensive presentation of the discussion and findings that emerged from the study and it went further to give a brief comparative section to find out the experiences of internal

migrant women in accessing maternal healthcare and whether these differ from those of external migrant women. The findings emanated as a result of the study trying to find out the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown. Overall the study provided useful insights into an area that is not yet widely known- Exploring the governance of maternal health. The case of migrant women living in Jeppestown, Johannesburg South Africa. The following chapter will provide a summary of the main findings, conclusion and recommendations.

Chapter Five: Conclusion and Recommendations

5.1 Summary of Main Findings

The report has made an attempt explore the governance of maternal health using the case of migrant women living in Jeppestown, Johannesburg South Africa. The current chapter aims to discuss the summary of the main findings giving the different conclusions drawn from them and providing recommendations from the study. The findings were based on the study's research question: (What are the health governance issues influencing access to public maternal healthcare services of migrant women in Jeppestown) where five major themes were drawn from the participant's narratives. It needs to be emphasised that, the themes that emanated from this study do not represent or reflect the only health governance issues influencing access to public maternal healthcare services of migrant women because health system governance is complex and difficult to assess simply because the concept of governance originates from different disciplines and that it is also multidimensional. Therefore, the conclusions drawn from this report do not lend themselves to all-inclusive application as they are specific to the case of migrant women living in Johannesburg. This study further explored the experiences of internal migrant women and give a comparative to find out whether their experiences in accessing maternal health differ from those of external migrant women.

Five major themes came up, which represents the findings of the study. The findings of the study included the realisation that free access to health has its consequences (with participants having different and varied sentiments of free access to health) in terms of governance in as much as it is a very good policy initiation by the South African government leading to the theme of the paradox of free access to health: the twofold narrative, linguistic barrier a challenge to the provision of equitable and effective health care for migrant women; staffing and burnout; initiation of ANC: a governance of maternal health concern. In all these five themes, this study picked up that the general picture from the participants was basically portraying migrants as the major reason for all the negativity that the public healthcare system experiences with most of the narratives being unfounded, simplistic assumptions related with political and scaremongering and the scapegoating of migrants especially foreign nationals.

The results reveal that most healthcare providers were playing a blame game on the migrant women accessing public maternal health themselves as abusing and misusing the policy of free access to health and also blaming those responsible for implementing health policies for not taking an all-inclusive approach and involving the healthcare providers and frontline staff who are the street level bureaucrats in providing health care to these migrant women. This was a very important finding as

the healthcare providers raised important aspects regarding free access to healthcare stating that free access to health is a good initiative, but the question asked is who deserves free access, how well and inclusive was the policy implementation and whether the policy is not divorced from reality on the ground which then leads to worrying health outcomes of often good policies. Impacts of free care have been multiple and varied leading to health governance issues influencing access to public maternal health of migrant women. The issue of free access to health was the entry point of all other themes that emanated from this study.

The study findings were guided by the access to healthcare framework also known as health access triangle coined by McIntyre. Where access according to Mclntyre et. al. (2009) is based on three dimensions, which are availability, affordability and acceptability. This framework was relevant to the current study as it assisted in unpacking the various dynamics between migrant women accessing public maternal healthcare and healthcare providers. The framework acted as a guide and useful tool in looking at the relationship between governance of health issues, healthcare providers and those seeking the services (migrant women). Since this study was conducted in an urban space the framework guided in bringing out the various issues in migration and health discussions. This assisted in showing the similarities and differences in types of migration and access to health care challenges faced by migrant women as well as misconceptions presented by previous researches on the aspect of accessing public health in urban settings and the need for health policy to engage more broadly with mobility and health. Throughout the study, from the framework the most important aspects that the framework assisted in bringing out was access and acceptability. Acceptability refers to the relationship between the healthcare provider and the patient in terms of attitudes and expectations, as these will influence the ability of individuals to receive care (McIntyre et al 2009). From the study, healthcare providers generally do not accept migrant women as evidenced by the findings and this has proved why migrant women basing on this study face challenges when accessing public maternal healthcare.

The study also discovered linguistic barrier is a is a profoundly rooted structural feature of the public health system incumbering the provision of equitable and effective access to health making it a health governance issue. The issue of linguistic barrier leads to othering of non-nationals by the healthcare providers as they cannot speak local languages and providers are of the habit of asking these women to bring their spouses, friends or interpreters whenever they come to seek maternal health care services which then compromises issues of privacy and confidentiality when seeking healthcare. The healthcare providers raised concerns that they could not get the history of the migrant women when they came for maternal healthcare services because of the language barrier which is a major problem in facilities leading to experiences faced by migrant women causing challenges in governance of

maternal health. Language is very important in health provision especially for accurate and effective history taking and when establishing rapport and trust between the healthcare provider and the patient. Of interest is that the National Health Act (2003) however, states that health providers must inform patients in a language they understand about their health status and treatment options yet most of the healthcare providers are reluctant to speak English preferring their vernacular or local language when attending to non-nationals. Hussey (2013), states that overlooked language barrier remains a challenge in providing healthcare in South Africa. There is need for an adoption of a 'migrant aware' health policies which guarantees universal access of healthcare by all to ensure equity in the distribution of healthcare services.

McIntyre et al, (2009) on access to health care framework emphasises on accessibility, affordability and accessibility where acceptability refers to the relationship between the healthcare provider and the patient in terms of attitudes and expectations, as these will influence the ability of individuals to receive care. This study concludes through findings that issue of linguistic barrier is linked to the notion of acceptability where there are differences in languages between healthcare providers and migrant women accessing maternal health which leads to them not receiving proper care or no care at all. There is need for language to be seriously considered when addressing and assessing the issue of acceptability in the healthcare sector especially when it comes to communication between healthcare providers and health seekers for the National Health Act (2003) however, states that health providers must inform patients in a language they understand about their health status and treatment options.

Adding on to the access triangle is the issue of accessibility where the issue of documentation hinders access to healthcare for the healthcare seekers because they are in constant fear of being asked for documentation when they report for services. Migrants without identity documents tend to regard clinics and hospitals as spaces to fear rather than seek relief. There is need to include the long-time debated notion of documentation when assessing accessibility in the access to healthcare framework. The health policy through the National Health Act (2003) stipulates that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities regardless of nationality, documentation and residence status. This is not the case because migrant women are constantly asked to produce documentation and give their residential address when they visit healthcare facilities for ANC and maternal health related services. The policy directives are forever flouted in public hospitals and clinics. This study concluded that issue of documentation is a contested issue around facilities even in South Africa in terms of access to social services and resources including access to health and as far as maternal health is concerned, documentation leads to delay in the initiation of ANC by the healthcare seekers which has negative health outcomes. Migrant women face challenges with the police and the immigration officers regarding documentation in the city and in the

absence of authorized directives to the contrary the healthcare providers end up abusing their positions when these healthcare seekers come for healthcare services as they have power to withhold services by demanding documentation influencing the way in which those services are rendered. With this in mind, this study concludes that the issue of demanding documentation from healthcare users has to addressed and considered when looking at accessibility in the access to healthcare framework for it influences the access of healthcare seeker when seeking public maternal healthcare in facilities.

The study also gave a comparative looking at the experiences of internal migrant women in accessing public maternal healthcare so as to find out whether these experiences differ with those of external migrant women. The study concluded that healthcare providers provide different services and treatment for the two types of migrant women when they access public maternal health. Internal migrant women receive services of a higher standard in terms of access to maternal health and their experiences of accessing maternal healthcare services proved to be a better experience basing from the findings of this study with external migrant women being treated indifferently. Andersen (2004:2005) states that healthcare providers practice what he calls "differential treatment" whereby healthcare providers distinguishes between those who are entitled to quality services and those who are not. Internal migrant women experience better quality care due to the fact that they are South African nationals and they are treated with attentive kindness and respect (Andersen, 2004) whereas external migrant women are treated with discourtesy and impatience being yelled at, ordered around and discriminated against simply because they are non-nationals. However, across the board both women complained on the issues of lengthy waiting periods in the clinics when accessing maternal healthcare services.

The study also found out that Health governance frameworks highlights the importance of governance in explaining how health systems function and achieve desired population health outcomes. Abimbola et.al., (2014) citing van Olmen et. al. (2012) states that the interest in health system governance stems on the expectation that good governance leads to improved health outcomes. Nonetheless, health system governance frameworks can be hard to conceptualize due to the challenge of accounting for the roles and relations of a broad range of actors (Abimbola et. al.,2014). Health system actors incorporates among others governments, groups of individuals who at various levels of authority, have the capacity and obligation to carry out health system functions which incorporates generating resources, deliver services, provide oversight or apply influence over decisions.

The study also noted with concern that most of the frameworks used in this study are silent on the issue of migration, yet health system frameworks show the importance of governance in clarifying how health systems function and achieve desired population health outcomes. As highlighted

throughout this thesis, the focus of this study was not on the governance of the health system but it was on the governance of the way that healthcare seekers experience in maternal health which influences their access to public maternal health at facility level. Literature on the governance of health and the health system governance does not include migration at all and when looking at the frameworks on health governance and issues to do with social determinants of health, all these are silent and turn a blind eye on migration which then leads to worrisome health outcomes of migrant health seekers. Moreso, this study concludes and notes that language around mobility competent health systems and migration aware health systems and policies would be helpful and it is crucial that they are taken as a priority in governance of health system and frameworks. Governance of health should sufficiently engage with migration as this will pave way and encourage practitioners and researchers to think about migration when exploring, assessing and coming up with health governance systems as migration has become one of the most important determinants of global health and social development.

5.2 Recommendations

- Like many other researchers and various Universal health governing bodies have noted, this research also recommends the South African National Department of Health to ensure the health of migrant populations through a collection of actions vis-à-vis promoting migrant-sensitive health policies; promoting equitable access to health promotion, disease prevention and care for migrants amongst others.
- Health care providers in all the public health facilities should be constantly educated on Xenophobia and Health Institutions (Nursing Schools) should have a curriculum on Medical Xenophobia and ways to curb Xenophobia in Health facilities, this will help in the fight against discrimination of non-nationals seeking healthcare in South African public health facilities.
- Health Policy implementers should consult and include healthcare providers including frontline staff in the planning and implementation of the so-called health policies because they are the ones responsible for providing these services and to this they must have discretion in taking decisions that will enable them to react viably to those who seek health especially migrant women.
- DoH should work on the governance of Maternal Health and tackle Maternal health the same way it concentrates with other chronic diseases as this will help in reducing the maternal mortality rates that the country faces. Investment in maternal health is unsatisfactory to meet the SDGs and much greater resources are needed to scale up coverage of maternal health services.

- Department of Health should also consider teaching new languages in their Nursing Schools. There is need for healthcare providers to be taught new languages at grassroots level such as French, Portuguese and basic communication skills with patients seeking healthcare especially migrants from other countries. Though health facilities should introduce and invest in interpreters, healthcare providers need to at least be taught other languages from other countries as this will help curb communication barriers.
- The South African government should come up with ways to replenish the income lost through abolition of user fees and the introduction of free access to Health.
- Healthcare providers should not demand documentation from foreign nationals seeking public healthcare services as this scare them away from coming to health care facilities for most of them do not have documentation or are using expired documents. Healthcare providers should just ask foreign nationals to provide their residential addresses and also ask for their age and health history so as to give services. This will make most foreign nationals to seek healthcare with no fear.
- There is need for a research funding to be availed on governance of health so that researchers and health system actors can come up with a universal health system governance framework that is easy, speaks to the issue of migration and flexible to conceptualize. Health system actors incorporates among others, governments, groups of individuals who at various levels of authority, have the capacity and obligation to carry out health system functions which incorporates generating resources, deliver services, provide oversight or apply influence over decisions. Most of the frameworks used in this study were silent on the issue of migration, health system frameworks show the importance of governance in clarifying how health systems function and achieve desired population health outcomes.
- There is need for health care facilities to come up with mechanisms to curb the lengthy waiting periods that demotivates patients to attend ANC. Also, there is need to come up with incentives that will motivate staff in healthcare facilities as this will improve staff attitudes towards their patients.
- Government should revamp healthcare facilities by coming up with a budget or a Renovation's Fund every year allocated to renovate facilities and improve the infrastructure of these public health facilities.
- More supervised student nurses should be deployed in facilities with at least two or three supervisors who are assigned only for monitoring and supervision purposes as this will help with staffing issues in facilities and burnout.

- Lastly the researcher makes recommendations for future studies. Since this study was based on a small scale with generalised findings, the researcher recommends that larger studies with a more representative sample should be conducted in future.

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Appendices

Appendix A: Participant Information Sheet

Good day

My name is Moffat Machiwenyika and I am a master's student in Migration and Displacement at Wits University in Johannesburg. As part of the requirements for the degree, I am conducting a research to inquire into the governance of maternal health of migrant women. The case of migrant women living in Jeppestown Johannesburg, South Africa. It is hoped that this information may enhance the understanding of this study.

As part of this project I would like to invite you to take part in this study. Involvement in the study involves your participation in an interview that will last for approximately one hour. The interview would be conducted at a time and place that is suitable for you. With your permission, I would also like to record the interview using a digital device.

You will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for not participating. You may withdraw at any time or not answer any question if you do not want to. The information you provide will be kept confidential; the information you give to me will be held securely and not disclosed to anyone other than my supervisor. The data I collect will be anonymous as I will not be asking for your name or any identifying information, and I will be using a pseudonym (false name) to represent your participation, in my final research report. If you experience any distress or discomfort, we will stop the interview or resume another time. If you need any support or counselling services following the interview these are available free of charge or at a minimum cost

at JHB Counselling Services, Metropolitan Park Block B & C, 1st Floor, 8 Hillside Road Parktown Johannesburg, Tel +27(0)11 0389 7196

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

Yours sincerely,

Moffat Machiwenyika

Researcher Details: Moffat Machiwenyika, 1507060@students.wits.ac.za , 063 024 0471

Supervisor Details: Jo Vearey, jovearey@gmail.com, 072 392 7034

Appendix B: Consent Form

Appendix C: INFORMED CONSENT FORM:

Tittle of research project: Exploring the governance of maternal health. The case of migrant women living in Jeppestown, Johannesburg South Africa.

Student name: Moffat Machiwenyika

Student email: 1507060@students.wits.ac.za

Student contact number: 0630240471

Supervisor name: Jo Vearey (Prof)

Supervisor email: jovearey@gmail.com

Supervisor contact number: 072 392 7034

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

Shaun.Schoeman@wits.ac.za

Contact Number: +27 11 717 1408

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

I understand that all information will be confidential and my responses anonymised. It has been explained that anonymity might not be fully guaranteed.		
I accept for this interview to be audio taped		
I accept the use of verbatim (direct) quotes from this interview		

FOR WRITTEN/SIGNED CONSENT

PARTICIPANT:

Printed Pseudonym of Participant Date

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

Signature Date

Appendix C: Interview Guide for Healthcare Providers

Appendix B: Interview Guide

Tittle of research project: Exploring the governance of maternal health. The case of migrant women living in Jeppestown, Johannesburg South Africa.

Hello,

My name is Moffat Machiwenyika, I am a student at the University of Witwatersrand studying MA in Migration and Displacement. Firstly, I would like to thank you for agreeing to take part in this research which is concerned with exploring the governance of maternal health. The case of migrant women living in Jeppestown, Johannesburg.

Health governance concerns the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population.

Questions

Can you please tell me where are you from?

How long have you been living in Johannesburg?

How long have you worked in this clinic/institution?

What is your role at the clinic/institution?

What are the biggest challenges in providing quality care at this clinic? (Omit "at this clinic" if it's a health official)

What do you understand by the term migration?

1. Do you consider yourself to be a migrant in this city? If so why?
2. If you are to give an estimate (percentage) of migrants in Johannesburg alone (Gauteng Province), how many would you say currently reside in Johannesburg? Probe internal/external
3. How long have you worked in this city and what is your position at this facility/department/institution?
4. What does your work entail? Brief description

5. What do you think are some of the maternal healthcare challenges you are facing at this facility?
6. Do you think migration affects health system in Johannesburg in terms of access? Explain
7. –Does migration affect health system in Johannesburg? Explain
8. How do you determine that someone is a migrant?
9. How many migrants do you feel visit this facility a month if you had to guess?
10. Why do you think they come to your clinic?
11. Do you think migration affected the services you provide? If yes probe in what ways?
12. Do you think it has affected access to services (Probe specifically maternal health, immunisation, and child nutrition)?
13. Does it affect local patients? Probe if yes, how?

Governance, local response, management responsibility of maternal health issues.

Since this study is concerned with exploring the governance of maternal health using the case of migrant women in Jeppestown, Johannesburg I will now ask questions relating to health governance, migration and maternal health

1. How do you understand maternal health issues?
2. How do governance actors conceptualise migration and health when formulating and implementing health policies?
3. What are the general provisions when implementing maternal health policies for migrant women? Are these provisions usually met? If yes how? If no, why?
4. Do you feel that in terms of maternal health of migrant women living in South Africa, and in this case Johannesburg, governance actors have a responsibility when implementing health policies? (If yes/no give reason to your answer)
5. How is maternal health managed in the city?
6. What some of the local level factors influencing access to public maternal health of migrant women?

Response to migrant women experiences in accessing maternal health in Johannesburg: With me here is a script from some of the research that was carried out on the experiences of migrant women accessing maternal health in the inner city of Johannesburg:

*"When I was in labour I went to Hillbrow Hospital but the experience was not good at all. When I got there I was told that all beds were full, they then told me to sit on a chair although I was in pain and about to deliver. I sat on the chair until I saw that it was no longer comfortable on the chair and the baby was almost coming out, I then told the nurse and she shouted at me saying I did not bring a bed from Zimbabwe therefore I should stop being a nuisance and sit where I was told to sit. I then went to the labour ward without permission from the nurse on duty and I helped myself to the bed. The nurse never bothered to come to me and I delivered my baby on my own and I woke up and put the baby away as I feared that the blood would affect him…….. " (**Extracted from Makandwa, 2014)***

"I think it was the first day I went to register. We were all taken inside, we were asked questions to do with maternity and child birth, like why babies need to be immunized against diseases like Polio. We were all mixed foreigners and locals, then a Zimbabwean woman responded in English and she was send away. They asked another question and picked on a Zimbabwean again and she responded in English and she was send out again that's when the nurse said if you know you don't understand or speak Zulu you better go, if you are Zimbabwean why do not you go for antenatal in Zimbabwe? I was only left alone because I can speak a little Zulu so that's how I survived". I registered but later own I had problems with my legs. I went back to the hospital and to explain my problem in Zulu was a problem I had to use English to be understood, that's when I was told they could not assist me I had to go to Zimbabwe". **Extracted from Makandwa, 2014**

1. What is your response to this statement in terms of governance of maternal health issues of migrant women in South Africa?
2. What should be done for such scenarios to be avoided in future?
3. What should maternal health policy implementers consider when dealing with issues of migration and health?
4. Are there any protocols in place in this clinic about how to work with/treat migrant patients?

Do you have any questions or do you feel you have anything to add on what we have been discussing?

********Thank you for your time********

Appendix D: Interview Guide for Migrant Women

Exploring the governance of maternal health. The case of migrant women living in Jeppestown, Johannesburg South Africa.

Section 1: Background information and migrant status

- How old are you?
- Which Province were you born?
- How long have you been in staying in Johannesburg?
- Why did you leave your home town to come to Johannesburg (probe reason for in-migration to Johannesburg)?
- Who are you staying with?
- Do you and those you are staying with have any documentation challenges? (probe for strategies they employ to overcome those challenges) (for cross-border migrants).
- How many children do you have?
- I would like to confirm when did you have your last birth and how many births have you had here in Johannesburg South Africa and how many in your Province?

Section 2: Migration & Health

- What do you understand by the term migration?
- Do you consider yourself to be a migrant in this city?
- Do you think foreign women who come here to access maternal health at this clinic/facility affects the locals access to health here? (probe to find out if migration is affecting health access for locals)

Section 3: Maternal healthcare experiences

- Please tell me about your experiences with antenatal care in healthcare facilities you have used here in Johannesburg starting with your oldest child (probe for when did they go there and did they use more than one healthcare system) (also probe in Jeppe clinic).
- What kind of services did you receive here during your pregnancy and delivery period? (probe for where did they get them) (Jeppe Clinic).

- How did you feel about those healthcare services you received/ you are receiving here in Johannesburg? (probe if they have choices where to go to get these healthcare services)
- For each health system/facility experiences with each of your pregnancies and birth how did you feel about healthcare service providers' attitudes and environment of healthcare facility?
- Did you have any communication problems with healthcare service providers? (Probe for how they were solved)
- How did you find the cost of healthcare in the public sector and other sectors here in Johannesburg? (probe on how they managed to go about in settling the costs)
- In general how would you characterize your experiences with pregnancy and delivery here? (probe for what they like and dislike about their experiences with antenatal care here)
- Did you face any challenges during your pregnancy and delivery period? (probe for what services they seek to solve these challenges)
- How has been the health care providers (nurses) attitude towards you when you came for antenatal visits and follow ups at this clinic?? (probe)

- Are there any challenges that you face when you visit the clinic/facility during your antenatal registrations and follow up visits??

Section 4: Future plans

- Would you return to this public healthcare facilities with your next? (probe why they will act in that manner)
- Would you recommend your friends to use healthcare facilities in Johannesburg/Jeppe during pregnancy and delivery? (Probe for what makes them say that).
- What could have been done/should be done to improve your experiences during pregnancy and childbirth?
- What do you think should be done to improve service delivery in facilities for maternal health??
- What would you recommend to health policy implementers when dealing with issues of migration and health especially with maternal health?

******** Thank you for your time ********

Appendix E: Ethics Clearance Certificate

Research Office

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

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H17/09/20**
PROJECT TITLE	Exploring the governance of maternal health: The case of migrant women living in Jeppestown, Johannesburg South Africa
INVESTIGATOR(S)	Mr M Machiwenyika
SCHOOL/DEPARTMENT	Social Sciences /
DATE CONSIDERED	15 September 2017
DECISION OF THE COMMITTEE	Approved Permission letters are required before data collection can commence
EXPIRY DATE	15 October 2020

DATE 16 October 2017 **CHAIRPERSON** J. Knight
(Professor J Knight)

cc: Supervisor : Professor J Vearey

DECLARATION OF INVESTIGATOR(S)

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

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

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

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix F: Permission To Carry Out Research

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Joburg
a world class African city

JOHANNESBURG HEALTH DISTRICT

Health Sciences Research Ethics Committee
University Of The Witwatersrand
Johannesburg , South Africa
1507060@students.wits.ac.za
DRC Ref: 2017-11-001

NHRD Ref no: GP_201710_029

Enquiries: Dr EM Ohaju
Tel: 011 694 3888 Cell: 076 8831659
Email: Elizabeth.Ohaju@gauteng.gov.za

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

Dear MR Moffat Machiwenyika:

Re: **Exploring the governance of maternal health. The case of migrant women living in Jeppestown, Johannesburg South Africa.**

Your application dated **2017/10/18** 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: The research can only commence after you submit an ethics clearance certificate from a recognized institution; **JEPPE CLINIC, OR TAMBO CLINIC.**

- This facility will be visited from **12/12/2017 to 12/12/2018**
- You will report to the Facility Manager before initiating the study.

Region	Regional Health Manager	Contact No.	Cell phone
ABEF	Ms Matlala	011 440 1259	082 307 0267

- 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.