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STREET LEVEL INTERFACE: THE INTERACTION BETWEEN HEALTH PERSONNEL AND MIGRANT PATIENTS AT AN INNER CITY PUBLIC HEALTH FACILITY IN JOHANNESBURG

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

Johannesburg, 2010

Declaration

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



Khangelani Moyo

24 May 2010

Abstract

South Africa is home to a wide range of cross border migrants and the provision of healthcare to this segment of the South African population has been a topical issue in different forums. There are reports that some cross border migrants are denied access to healthcare despite the existence of legislation that allows them certain rights to public healthcare in South Africa and it is against this backdrop that this research is premised. The research focused on understanding the dynamics of the interaction between frontline healthcare personnel and migrant patients at an inner city public health facility in Johannesburg and used the concepts of street level bureaucracy, access to healthcare and interface analysis in guiding the research and conceptualising the data. Participant and non participant observation, interviews, focus group discussions and conversations were employed to gain insight into the nature of interaction between frontline staff and cross border migrants. The findings suggest that documents are not a requisite for cross border migrants to access healthcare and the decisions made by frontline healthcare personnel are influenced by working conditions, frustrations, attitudes of staff and language and cultural differences between the frontline staff and cross border migrants. The study concluded that while the different behaviour patterns of the frontline staff impact on the degree of fit between cross border migrants and the public health system outright denial of access to healthcare for cross border migrants by frontline staff is not common.

Dedication

To my late brother Honest, REST IN PEACE!

Acknowledgements

I am indebted to the Almighty God who gives me strength. This work would not have been possible without the patience and dedication of my supervisor Dr Lorena Nunez Carrasco to whom I owe a multitude of gratitude. Her comments and grilling kept me focused till the completion of this work. Joanna Vearey deserves special mention for taking the role of co – supervisor. She spared time to critically read my draft and offer some valuable comments and ideas on street level bureaucracy and healthcare access. I would like to express my gratitude to the participants of this research and the facility management at Hillbrow Community Health Centre for tolerating my intrusion. Francesca and Evans from MSF are also thanked for the help in organising meetings with the participants from the Central Methodist Church. My classmates and friends also gave me the comradeship that is priceless when engaged in a project of this magnitude especially Barbra and Dudu. I am also indebted to my family for the support they have given me all the years that I have been studying. Last but not least I would like to thank my fiancé Pauline for being there for me and giving me courage when I thought I couldn't continue writing.

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List of Acronyms/Abbreviations

CMC	Central Methodist Church
CoRMSA	Consortium for Refugees and Migrants in South Africa
DHA	Department of Home Affairs
FMSP	Forced Migration Studies Programme
GDOH	Gauteng Department of Health
HCHC	Hillbrow Community Health Centre
HRW	Human Rights Watch
ID	Identity Document
JHB	Johannesburg
NGO	Non-governmental Organization
SADC	Southern African Development Community
MHF	Migrant Health Forum
MSF	Médecins Sans Frontières
NDOH	National Department of Health

RNA	Refugee Nurses Association
RSDO	Refugee Status Determination Officer

Chapter 1: Introduction and Background to the Study

South Africa is home to a large cross border migrant population, most of whom are citizens of neighbouring countries and a significant number are undocumented (Crush 1999). The term cross border migrants refers to the different categories of foreign migrants residing temporarily or permanently in South Africa and includes inter alia, refugees and asylum seekers, economic migrants and undocumented migrants. Drawing from the 1951 Refugee Convention relating to the status of refugees, a refugee would be referred to as a person (documented or undocumented), who has fled the country of his or her nationality owing to well founded fear of being persecuted for reasons of race, religion, nationality, and membership of a particular social group or political opinion (UNHCR 2005). When the claim for refugee status has not yet been definitively evaluated the individual is referred to as an asylum seeker (UNHCR 2005). Undocumented migrants are those without a residence permit authorising them to regularly stay in their country of destination. They may have been unsuccessful in the asylum procedure, have overstayed their visa or have entered irregularly (PICUM)[1]. The term economic migrant in this context shall be used to refer to someone who has emigrated from one country to another for the purposes of seeking employment, livelihood opportunities, or an improved financial position (Chiswick 1999).

This study is grounded on the evidence shown in a number of recent studies that cross border migrants in general and undocumented migrants in particular face challenges in accessing healthcare in the South African public health sector (Pursell 2005; CoRMSA 2008; Vearey 2008; CoRMSA 2009; MSF 2009;

[1] http://www.picum.org/article/undocumented-migrants

Tolboom 2009; HRW 2009a; HRW 2009b). This issue has dominated discussions in the Johannesburg Migrant Health Forum[2]with one of the most common challenges cited being that healthcare providers demand South African Identity Documents (ID) as requisites for treatment (MSF 2009). The associated rejection and poor treatment of cross border migrants persists within the public health system despite the presence of legislative and policy documents (South African Constitution 1996, Refugee Act 1998, National Health Act 2004, National Department Of Health (NDOH) Revenue Directive BI 4/29 REFUG/ASYL 8 2007, NDOH Memo of 2006 and Gauteng Department Of Health (GDOH) Directive 2008[3]) that entitle different categories of migrants to access distinguished types of healthcare (CoRMSA 2009). None of the studies (Pursell 2005; Vearey 2008; Vearey and Richter 2008; MSF 2009; Tolboom 2009) focusing on the challenges faced by cross border migrants in accessing healthcare have examined the point of contact between the healthcare providers and cross border migrants. Taking into account the different challenges that cross border migrants face in accessing healthcare in the public health system, this study recognises the need for a deeper understanding of the dynamics involved in the interaction between healthcare providers and cross border migrant patients. This is done with a focus on both migrant and healthcare providers' perspectives rather than focusing on each of them separately. The argument is that it is not enough to focus on each of these separately but to look into the point of contact between cross border migrants and healthcare providers. This point of contact is what Long (2001: 243) calls the 'interface' and is defined as the point where different social groups interact. Analysing the interaction between healthcare providers and cross border migrants at this point reveals

[2] This is a forum of NGOs and CBOs coordinated by the Wellness Centre and Reproductive Health Research Unit in Johannesburg with the aim of monitoring and acting upon challenges that migrants face in trying to access public health services within South Africa, and to work towards improving this (Vearey and Richter 2008).
[3] See appendix 4 and 5

some of the issues that impact on the decisions made by the healthcare providers to either give or deny healthcare access to cross border migrants.

This study therefore focuses on at least three areas. Firstly the study looks at the interaction between healthcare providers and cross border migrant patients with a view to understanding the circumstances that impact on this interaction. The important aspect is what happens at the street level interface[4] and how it influences the decisions made by healthcare providers relating to migrants' access to public healthcare. Secondly, the study looks at the discretion that the healthcare providers have in making decisions at the interface and in their interpretation and application of policy regarding the provision of healthcare to migrants. Thirdly, the study focuses on the identity of migrants in order to understand whether migrants' nationality, language and other aspects of their identity play any part in the decisions made by healthcare providers to either give treatment to migrants or not. To achieve this, the study focuses on a specific component of the healthcare providers i.e. the frontline staff who are responsible for the registration of patients at the main point of entry to the healthcare facility. This includes clerks, receptionists and other staff members who attend to patients at the front desk. For the purposes of this study, the terms frontline healthcare providers and frontline staff would be used to refer to the above mentioned unit of analysis, and the terms migrants would be used in reference to cross border migrants. The South African migration context and the background against which this study is conceptualised are discussed in the following section.

[4] Street level denotes the level or place at which the public health personnel meet with their public health clients and interface refers to the encounter between the frontline healthcare personnel and migrants.

1.1 South African Migration Context

Cross-border labour migration between South Africa and its neighbours dates back to the mid-19th century, when the South African diamond and gold mining industries were founded and the country began its trek towards a modern industrial economy (Crush 2003). Migration from neighbouring countries has taken many forms ranging from the regulated contract labour system in the mines to the "informal, unregulated or clandestine" movements across borders (Crush 2000: 13). Of the 400,000 mine workforce in the early 1970s over 80 percent were contract workers from outside South Africa (Crush 2000). Most of the workers came from neighbouring countries such as Zimbabwe, Lesotho, Malawi and Mozambique. The number of cross border migrants has continued to increase especially in the post 1994 period which marked the end of the apartheid regime. Statistics on the actual number of cross border migrants are difficult to ascertain but generally range from around 500 000 in the early 1990s to over a million in the post 1994 period (Handmaker and Singh 2002; Solomon 2003; Crush, Williams et al. 2005; CoRMSA 2009). In addition to cross border migrants there have been significant increases in the count of local migrants[5] moving into the urban areas due to the political and economic liberalisation of South Africa (Landau 2006a). The numbers of cross border migrants include a significant proportion of refugees and asylum seekers (Vearey and Richter 2008). It is important to underline that cross border migration into South Africa is mostly regional and involves large numbers of nationals from neighbouring countries. The political and economic crisis in Zimbabwe in the post 2000 period has forced large numbers of people to migrate into South Africa, adding to the increasing number of cross border migrants already residing in South Africa (Makina 2008). Of the 256 000 asylum applications

[5] The term local migrant refers to migrants from within South Africa.

received by the department of home affairs in 2008 Zimbabweans constituted 45% (115 800) of this number (HRW 2009b: 15). This gives a glimpse of the extent of Zimbabwean migration into South Africa in the post 2000 period. Most of this migration is undocumented and difficult to quantify (Landau 2008).

1.1.1 South African Migration Context: The Challenges of Undocumented Migration

In what Agustin (2009) calls 'anti-immigration voices' she argues that rhetoric has shifted from the use and construction of victimhood through the allocation into categories of refugees and asylum seekers. The new rhetoric is that of 'economic migrants' used to describe people who are not seen to fit into the categories of refugees and are not entitled to the same privileges (Agustin 2009). Agustin takes the argument further and observes that, this arbitrary delimitation of migrants is used as a pejorative and 'an accusation against people who do not qualify as refugees from officially (and arbitrarily) designated conflicts' (ibid: paragraph 4). This has been the case with Zimbabwean asylum seekers; some of which do not even bother applying for asylum seeker permits because Refugee Status Determination Officers (RSDOs)[6] at the South African Department of Home Affairs do not consider them as deserving applicants. The reasoning behind such sentiments is linked to the narrow interpretation of the purpose of asylum which the RSDOs limit to the presence of war or other armed conflict. The assumption by RSDOs is that Zimbabweans are economic migrants rather than refugees (Landau, Ramjathan-Keogh et al. 2005; Vigneswaran 2007; Bloch 2008). This has had a profound effect on the status of some Zimbabweans in South Africa who have been forced to reside as undocumented migrants. The poor

[6] RSDOs are officials of the host country or UNHCR whose task is to establish whether an individual applying for asylum meets the eligibility criteria under international or national legislation (UNHCR 2005)

service delivery at the Department of Home Affairs affects even the conventional refugees who have to wait for long periods of time before they are issued with befitting documentation (Vigneswaran 2008). Research also suggests the presence of negative and xenophobic sentiment toward asylum seekers within the DHA, and an entrenched belief that applicants are an illegitimate drain on South African resources (CoRMSA 2009).

Observing trends in the European Union and other developed regions of the world, Agustin (2009) notes that for a migrant to merit sympathy from the host population they have to be anything but able bodied and willing to take any form of paid employment. This follows her observation of the hardening attitudes of European countries towards asylum seekers with charges that economic migrants are abusing the system. Similar tendencies have been observed by Crush in the South African context and are described in his argument that the public discourse 'constructs all migrants as "illegal aliens'' (whether they are from Lesotho, Liberia or Latvia); and all "illegal aliens'' as parasitic and by definition a direct threat to the material and social interests of all South Africans" (Crush 1999: 5). In discussing the migration pressures in contemporary migration discourse, Rogers (1992) argues that migration pressures in the sending countries are manifested in various ways. The argument is that the desire to migrate by the economically challenged populations exceeds the opportunities available to realise the desire (Rogers 1992). As a result the number of economic or labour migrants using the asylum system as a "surrogate immigration channel" increases (ibid: 39). The following section builds on the data presented above and looks at the historical dimension of cross border and internal migration and its linkages to the current public health problems that South Africa faces. To this end, there is a discussion of the inequalities in access to public healthcare for the whole South African population, as well as the

impacts that growing populations – including both natural growth and increased numbers of internal and cross border migrants could have on the public health system.

1.2 Migration and the South African Health Context

According to Lawn and Kinney (2009), the South African public health system struggles to cope with a multitude of problems that include the burden of communicable disease (especially HIV/AIDS), maternal, neonatal and child deaths, and deaths from injury and violence. Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) trace the problems of South Africa's young democracy to the years of apartheid wherein citizens were divided according to race and gender. These categories influenced citizen access to healthcare and determined the quality of healthcare provided (Coovadia, Jewkes et al. 2009). A key feature of these divides was the selective migratory regime of apartheid South Africa that created a rural labour enclave and dictated who was desirable in the city and who to exclude through some discriminatory policies (Crush 1999). The migrant labour system that was created for the service of apartheid mines and industry had the effect of articulating the modes of production between the rural agricultural economy and the urban mining industry. As a result migration became circulatory[7] and underlined the wishes of the imperialist in the design of the colonial city as a place where the blacks could only reside insofar as they were in servitude to the white colonial masters. Circulatory migration describes a situation that is common in rural to urban migration in which rural people make temporary

[7] Describes a situation that is common in rural to urban migration in which rural people make temporary movements of varying durations to different places but ultimately return to their starting place at some point in time (Bekker 2002, Chapman and Prothero 1983).

movements of varying durations to different places but ultimately return to their starting place at some point in time (Chapman and Prothero 1983; Bekker 2002). The linkages that had the effect of desolating the rural agricultural economy increased with the increase in the number of rural blacks coerced into the mining industry. According to Coovadia et al. the numbers "increased from 10 000 in 1889 to 200 000 in 1910, and 400 000 in 1940" (2009: 819). Migrant labour (both internal and international) became, and remained, a major influence on the social, economic, political and health developments in South Africa and the neighbouring source countries (Coovadia et al. 2009). Circulatory migration linked the disease burden in the urban areas with the rural areas with the result that TB cases increased in similar proportions in both areas. For instance, by the late 1920s, "more than 90% of adults in parts of the rural reserves of Transkei and Ciskei had been infected with tuberculosis" (ibid: 819). In addition to creating a rural labour reserve, the migrant labour system created conditions for the impoverishment of the majority black population. It also "contributed to many of the major current health problems through social changes which led to destruction of family life, alcohol abuse, and violence, particularly gender based violence" (Lawn and Kinney 2009: 2). The creation of these conditions and the historical patterns of segregation have had a bearing on the inequalities that characterise the current South African health system (Lawn and Kinney 2009). The healthcare access inequalities are discussed in detail in the following section.

1.2.1 Current Health Care Access Inequalities in South Africa

Coovadia et al. (2009) conclude that the South African health system has been characterized by fragmentation throughout history. It has been fragmented along racial and gender lines as well as between public and private facilities. This fragmentation has had a bearing on the transition from apartheid to the new democracy which Chopra et al. (2009) describe as being protracted and polarised. The argument is based on the lack of progressive realisation of the millennium development goals by South Africa (Chopra, Lawn et al. 2009). While work towards the realisation of these goals is ongoing, South Africa still grapples with an enormous disease burden which is characterised by the persistence of infectious diseases together with high maternal and child mortality and non communicable diseases. In terms of Charasse-Pouele´ and Fournier's argument a health system that is surrounded by a coexistence of economic and racial discrimination could have the effect of under servicing certain citizens while over servicing others because it ignores basic needs (Charasse-Pouele and Fournier 2006).

Placing their argument in the context of the global financial crisis, Moony and Gilson (2009) argue that the South African economy is operating at equilibrium and to deal with unemployment there is need for investment in more labour intensive industries. The argument is that the current unemployment rate in excess of 25% adds to and exacerbates the divide between the rich and the poor (Mooney and Gilson 2009). In addition Mooney and Gilson observe that the return to capital in the South African context is not comparable to the returns that accrue to labour and the difference in income between the capitalists and labour further stretches the inequality and poverty gaps. By implication health

expenditure is less in the bottom rungs of the South African economy and the key social determinants of health will continue to shape health inequalities in the country (ibid: 2). Mooney and Gilson's argument is reinforced by Charasse-Pouele´ and Fournier's observation that "the principle of legal equality does not imply effective equity, justice or immediate disappearance of discriminations, racial inequality of socioeconomic status and opportunities for social achievement" (Charasse-Pouele´ and Fournier 2006: 2899). Outside of health inequalities South Africa ranks amongst the most unequal countries in the world with a Gini coefficient (the closer to 1, the greater the inequality) of 0.666 in 2008[8].

1.2.2 Impact of Migration on the Healthcare System

In the post 1994 period, healthcare policies are being transformed to conform to the WHO standards that stipulate a movement away from tertiary curative medicine to an emphasis on primary and preventive healthcare practice (Stack and Ndletyana 2001). Curative tertiary medicine according to Stack and Ndletyana, looks at the needs of the sick and injured, and depends on doctors, while preventive primary health care is concerned with preventing illness and injury through information literacy, immunisation, and the promotion of sound dietary, hygienic, and behavioural practices. "The first point of entry for South Africans to health services is now at primary level through local clinics and community health centres" (Cullinan 2006:7). These facilities treat what health professionals call "ambulatory patients", or people who are able to walk and do not need to be confined to bed (Cullinan 2006). Vearey, Nunez and Palmary (2009) underscore the importance of maintaining sustainable health

[8] South Africa development indicators 2009 (http://www.thepresidency.gov.za/learning/me/indicators/2009/indicators.pdf)

provision that reaches those that are living on the margins of welfare provision. The argument is that the processes of urbanisation and migration engender a multiplicity of developmental and urban health needs.

Research has shown that migration is not a major concern in the South African healthcare system (Vearey, Nunez et al. 2009). Migrants report low usage of public health facilities once in South Africa and this counters the notion that migrants increase the burden on public health resources (Vearey 2008; Pophiwa 2009). In a survey of 487 households looking at both South African nationals and non nationals in the Sol Platjies informal settlement and the inner city suburbs of Berea, Hillbrow and Jeppestown in Johannesburg Vearey et al. (2009) concluded that contrary to media reports and prevailing sentiment an overwhelming majority of cross-border migrants are not necessarily health-seeking migrants but come to South Africa for economic and political reasons. A great number of the surveyed migrants (more than 50%) reported that they would go back to their home areas in the event that they became too sick to work (Vearey, Nunez et al. 2009). In addition, a significantly low number of cross border migrants reported ever bringing a sick relative to seek treatment in South Africa, with the rest citing the difficulties and costs of repatriating the body of the person in the event that they died here as inhibitors. In cases of sick relatives they would rather send money or go back home and care for the person (ibid). These findings, according to Vearey et al, challenge the assumption that cross-border migrants spread diseases and put a strain on the resources that are meant to benefit South African nationals. However these findings have come a little too late as the ideas of health seeking migration especially from Zimbabwe are entrenched in the minds of service providers who continue to subject migrants to sub human treatment in some public health institutions. The treatment meted on the migrants is often

oblivious of the fact that migrants accessing healthcare in the public sector are often people in the productive age groups (Evans 1987). This underlines the fact that migration is still a process undertaken by the young and often healthy members of the sending countries (Evans 1987). As highlighted in the preceding sections different categories of migrants have certain rights to access healthcare that are recognised by legislation and policy documents in South Africa (Vearey 2008, CoRMSA 2009). The discussion on these documents which include the South African constitution, NDOH directives and international human rights frameworks is presented in the next section.

1.3 The Place and Rights of Migrants in the South African Health System

1.3.1 The South African Constitution

"We, the people of South Africa … Believe that South Africa belongs to all who live in it, united in our diversity …." (Preamble of the SA constitution)

The South African constitution has been interpreted as guaranteeing healthcare access to all and the state as obliged under section 27(2) to make reasonable efforts to achieve the realisation of rights enshrined in subsection 1 (Landau 2006b, Vearey and Richter 2008). The following sections of the South Africa constitution have been interpreted to afford migrants some entitlements to certain social services including healthcare in South Africa (Landau 2006b, Vearey and Richter 2008).

Section 27 of the South African Constitution states that:

1. Everyone has the right to have access to:
    a. Health care services, including reproductive health care;
    b. Sufficient food and water; and
    c. Social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

3. No one may be refused emergency medical treatment.

While this part (section 27) of the constitution is inclusive as will be explored further in this paper, it does not clarify the place of the undocumented migrants by virtue of their assumed absence. Even the numbers of the undocumented migrants are subject to intense debates with attempts at quantifying them quite futile in both the public and private spheres. The estimates range from below a million to several millions depending on the source and statement being made (Handmaker and Singh 2002). The clause that could provide respite to the undocumented migrants is 27(3) which could be interpreted to entitle everyone regardless of nationality and legal status to life saving healthcare in South Africa. The right to emergency treatment is also recognised in the National Health Act (NHA) of 2004. Section 5 states that, "A health care provider, health worker or health establishment may not refuse a person emergency medical treatment" (NHA 2004: 20). The situation is different for refugees and asylum seekers who are entitled to the same rights and protection as South Africans, much more than just life saving or emergency treatment. While there have been strong arguments to the effect that the state has an obligation even to the undocumented migrants based on section 27 of the constitution (Landau 2006b; Vearey 2008; Vearey and Richter 2008), it seems unlikely that the South African government sees itself obliged to exercise such an obligation or does not feel compelled to do so. The situation of undocumented migrants is therefore desperate and claiming entitlement in terms of the constitution is analogous to placing a foothold on slippery ground as the chances of success are limited. In addition to the rights recognised in the constitution, the South African National Department of Health has issued policy directives enabling refugees and asylum seekers with or without documents to access healthcare in the public health sector. These policy directives are discussed in the next section.

1.3.2 Policies and Directives

The NDOH released a memorandum in 2006 clarifying that possession of a South African identity booklet should not be a prerequisite for eligibility to access ART[9] (Vearey 2008). Vearey argues that the memo has implications for South African citizens as well as non-citizens but some health care facilities still consider an ID book as a requirement in accessing public healthcare. In addition a Financial Directive has been issued by the NDOH (September 2007) and another memorandum from the Gauteng Department of Health (April 2008) to the effect that refugees and asylum seekers with or without a permit should not be denied access to basic health care and ART, and that the South African identity book should not be made a requirement to access health care. The different directives from the NDOH add to the ambiguity and lack of clarity regarding the entitlements of undocumented migrants and paint a picture that while not necessarily denying access to health care by undocumented migrants the NDOH does not guarantee it. Seemingly the ambiguities do not only affect undocumented migrants, but have raised further concerns as outlined by CoRMSA[10] in their 2009 report. CoRMSA (2009) observes that in spite of raising concerns in their previous reports (2006, 2007 and 2008) refugees and asylum seekers continue to have negative interactions with healthcare providers in public institutions and the rights to access healthcare and ART by refugees and asylum seekers in the public health system are still shrouded in ambiguity. The directive on documentation appears to have been issued in recognition of the inability of the department of home affairs to effectively document citizens and undocumented refugees and

[9] Anti Retroviral Therapy (ART) refers to the chronic use of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression from HIV to AIDS.

[10] The Consortium for Refugees and Migrants in South Africa (CoRMSA) is a nongovernmental organisation comprised of organisations and individuals committed to the promotion and protection of refugee and migrant rights entering or living in the Republic of South Africa (CoRMSA 2009).

asylum seekers (HRW 2009b). Landau (2006) highlights what he calls inability or unwillingness on the part of the healthcare providers to make a distinction between the different classes of migrants. The argument by Landau is that this failure to distinguish between the many categories and spaces occupied by migrants has the effect of creating a broad classification of everyone that is foreign and constituting a gross violation of the rights of even bona fide refugees and asylum seekers. The violation of rights is worse for the undocumented migrants who are neither refugees nor asylum seekers. My point is that, in the absence of any kind of clear legislation that specifically caters for undocumented migrants (by this I mean those that are irregular and do not qualify as refugees or asylum seekers) the healthcare providers are open to arbitrary decision making. The policy documents (NDOH & GDOH directives) specifically deal with cases where refugees and asylum seekers together with South African nationals happen to be without documentation and in need of healthcare. There is no inclusion of some criterion through which the healthcare providers can make a distinction between an irregular economic migrant and an asylum seeker or refugee if both do not have documentation. The rights of cross border migrants to access healthcare are also recognised in a number of international human rights frameworks. The following section discusses the place of migrants in the human rights frameworks and concludes with specific attention to the place of undocumented migrants in the international human rights framework.

1.3.3 International Human Rights Frameworks

There are a number of international legislative frameworks pertaining to migrant access to healthcare in host countries but the most appropriate and all encompassing convention to date is the International

Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (the Migrant Rights Convention). It is Bloch's (2008) contention that before the formulation of the Migrant Rights Convention, undocumented migrants often fell into a space of ambiguity as a category of migrants excluded or ignored from the mainstream legislation. In sum, the various pieces of legislation rendered them invisible and limited their options in terms of legal recourse in cases where their rights are violated. The only downside of the migrant rights convention is that in spite of being an elaborate paper it has only been ratified by 37 countries and worryingly so the majority of the countries are population exporters rather than recipients. The convention has been in existence for 19 years but no developed country has ratified or appended its signature to the document (Bloch 2008). South Africa is included in the countries that have not ratified the convention to date (CoRMSA 2009). The convention is binding and recognises the place of undocumented migrants in the economic structure of host countries and affords legal protection across the human rights spectrum. It is inclusive of all types of migrants and their families, and extends employment and civil rights to all migrants (ibid: 7). Bosniak (2004) argues that the creation of good legislation is not enough to improve the situation of migrants. The contention is that some rights afforded in the Migrant Rights Convention might be impossible to access for migrants, especially those that are undocumented (Bosniak 2004). The prohibitive factors include some well founded fears of being reported to immigration officials who could detain and deport them (Berk and Schur 2001; Castaneda 2009). In some cases there is a lack of promulgation or dissemination of information concerning the applicability and accessibility of the different rights covered in the legislation to both migrants and service providers. Regarding the situation in South Africa, it is plausible to make the point that as long as the government has not ratified the Migrant Rights Convention; undocumented migrants remain in the space where they are not covered by any legislation that is enforceable and legally binding on the part of the state. This, to me is the paradox of access in

which the undocumented migrants are in theory protected by the human rights framework but practically fall outside of any form of protection and are thus disempowered and vulnerable (Bloch 2008). The human rights framework is often less binding at the point of interaction between healthcare providers and migrants and leaves those who can only present the “suffering body” as their legitimate passport to accessing services with major problems (Fassin 2001).

1.5 Research Question

The research is aimed at answering the following empirical question:

> What is the nature of interaction between healthcare providers and migrants at the street level interface and to what extent does this contribute to migrants' access (or lack of) to healthcare?

The following sub questions have been developed to help answer the main question.

1. What kind of circumstances and baggage[11] do healthcare providers and migrants bring to the point of interaction and to what extent do these circumstances influence the nature and outcome of their interaction?

2. In the event that migrants are denied access to treatment, what informs the health care providers' decisions? Does the nationality, gender, health condition, language, and other aspects of the migrant's identity have a bearing on the decision making process?

3. How much discretion do the healthcare providers have over the application of policy?

4. What do the migrants say about healthcare providers' decisions (to provide or deny access to healthcare) and how do they view themselves in relation to the healthcare providers How do they describe their role at the interface?

In answering the broad theoretical question and sub questions the study utilises the theory of street level bureaucracy (Lipsky 1980, Moore 1987, Moore 1990), the concepts of access to healthcare

[11] Baggage is used to refer to the circumstances that have an influence on the street level decision making. These could consist of attitude, language, perceptions, frustrations, e.t.c

(Penchansky and Thomas 1981; Walt and Gilson 1994; Schneider, McIntyre et al. 2006; Walt, Shiffman et al. 2008) and interface analysis (Long 2001). These concepts are discussed in detail in the next chapter.

1.6 Overview and Organisation of the Research Report

The research report is organised into six chapters including this introductory chapter. Chapter 1 introduces the research, and summarises the aims and background of the research. The second chapter discusses the theoretical resources used to conceptualise the study. Chapter three discusses the methods employed in the research and includes a summary of the research process as well as the limitations of the study. Chapter four presents the findings of the research by looking at the perspectives of the migrants and NGO service providers as well as the frontline healthcare providers. Chapter 5 continues the presentation of findings and focuses on the agency of the healthcare providers through a discussion of patient categories and the issue of language at the frontline. The sixth chapter concludes the different arguments of the research and summarises the important points discussed in the entire study.

Chapter 2: Main Theoretical Resources

2.1 Introduction

This chapter reviews the theoretical resources used to frame the study and make sense of the findings. To this end, the focus is on defining how bureaucracy operates at the street level, defining the concepts of access to healthcare and interface analysis. The chapter concludes with a discussion of the main argument of the research and a summary of how the literature informs the debate on street level bureaucracy and migrant access to healthcare.

2.2 Defining Street Level Bureaucracy

The term and concept of street level bureaucracy has been debated widely in the public administration literature but assumed prominence in the late 70s with the work of Lipsky. Street level bureaucracies are public agencies such as schools, police and welfare departments whose workers are in direct contact with the public and have wide discretion over the dispensation of public services (Lipsky 1980). Street level bureaucracy is an extension of the general concept of bureaucracy which could be used to refer to

a formal, hierarchical organisation with many levels in which tasks, authority and responsibilities are systematically divided among individuals, offices, or departments, and coordinated under a central administration (Beetham 1996). It is the tenets of the concept of bureaucracy that are at the core of this research, particularly the association of the concept with public administration. Public administration, according to Beetham (1996) emphasizes the centrality of the 'public' and a conception of the 'public sphere'. Beetham adds that the concept of the public "suggests a form of administration which is carried out for the public, according to a norm or ethos of public service" (1996: 30). Drawing on the preceding discussion by Beetham (1996) it is worth noting that the public in the South African context is a contested space that includes migrants as well as citizens among the stakeholders and for whom policies are formulated and implemented. Street level bureaucracy is a function of the modern state that presides over the implementation of policies and is representative of the state in interaction with the public (Rynbrandt 2005, Dunsire 1978). The street level therefore connotes the lower reaches of the state or the interface between the state and the public, i.e. the ordinary citizen on the street.

2.2.1 Street Level Bureaucrats as Innovative Strategists

In the accounts of bureaucratic procedure detailed in the theories of Weber, Taylor and other organisational theorists, employees are portrayed as passive (Moore 1987; Moore 1990). Weber analyses organisations in terms of relationships between staff members in which each member is in a position of either giving or receiving orders (Albrow 1970). This argument has influenced Moore's (1987) views that in most organisational literature the street level bureaucrats are portrayed as merely

invoking technical procedures whose features are automatically prescribed. Moore (1987) contradicts the conventional organizational theories of Weber and Taylor and conceives street level bureaucrats as,

> …inventive strategists seeking technical, social and moral capacity and sophistication as well as strategic success in negotiating ambiguous work settings (1987: 74).

Moore's (1987) argument presupposes the existence of a lack of clarity and difficult circumstances in work settings and the presence of a conflict of sorts between the street level bureaucrats and management. This argument is represented in the literature on policy implementation where the common assumption is that the street level bureaucrats have incentive to pursue their own ends that are at odds with the interests of management (Riccucci 2005; Rynbrandt 2005).

2.2.2 Policy Implementation and Street Level Discretion

Dunsire (1978) posits that the process of implementation as represented by the verb 'implement' presupposes the existence of an object that must be carried into effect. The fitting object for a verb like implement would be policy (Dunsire 1978). Kelly argues that 'street level bureaucrats are the final implementers of public policy and their jobs are inherently discretionary' (1994: 119). Discretion in this instance refers to the judgements and choices that the street level bureaucrats make in the performance of their daily tasks (Maynard-Moody and Musheno 2000; Bovens and Zouridis 2002; Rudes 2005). Citing Hill (1997), Walker and Gilson argue that, 'the gap between objectives and outcomes is a demonstration of how policy is recreated through the process of implementation, rather than

implementation failure' (2004: 1251). The argument is that there is often a disjuncture between what senior level management prescribes and what actually happens at the street level.

In a study on the implementation and impacts of the free care, i.e. removal of user fees for all public primary care services in South Africa in the post 1996 period, Walker and Gilson (2004) define the role of street level bureaucracy in terms of the bottom up perspective. According to Walker and Gilson, the bottom up perspective, "emphasises the need to understand implementation systems and the actors responsible for implementation" (2004: 1251). The bottom up perspective subverts the top down discourse in policy formulation and posits that policies are created and recreated by the workers at the street level (Weissert 1994; Bovens and Zouridis 2002; Walker and Gilson 2004). Walker and Gilson argue that policies should be created in ways that are inclusive of the street level bureaucrats so that the street level bureaucrats could have space to contribute and make use of their discretion. The study by Walker and Gilson is focused on the way public health personnel implement new legislation and falls within the greater literature on street level bureaucracy that supports the innovativeness of the bureaucrats in dealing with ambiguous policies. Nkosi et al. (2008) discuss the implementation of two equity-oriented policies at two South African hospitals, the Uniform Patient Fee Schedule (UPFS) and Patients' Rights Charter (PRC) and argue that co-production[12] between health provider and patient in the implementation of policies is often seen by healthcare providers as being essential to health care provision, and an influence on health policy implementation. Their argument is that providers (and policy formulators) cannot fully control policy implementation where policies work through provider-patient interactions (Nkosi, Govender et al. 2008). Strong top down approaches to policy design and

[12] Coproduction refers to 'the need for providers and patients to work together' (Nkosi et al 2008:5)

implementation are therefore, often simply inappropriate for health policy because they do not take into account the dynamics and interactions that characterise the point of interaction (interface) between street level bureaucrats and clients (Bovens and Zouridis 2002). Instead, implementer discretion is required to encourage patient co-operation which is essential since policies often require adaptations to address patient and contextual influences. According to Nkosi et al co-production has to be successful in order to prevent the lapse by providers into adopting street level bureaucrat coping strategies that include "labeling and rudeness, and prompt a cycle of negative behaviours and attitudes" (2008: 5).

Hupe and Hill (2007) argue that street level bureaucrats have access to resources that their public clientele do not have and by implication they often are better placed in relation to their clients. This argument is implicit in the position of Maynard – Moody and Musheno (2003) that the street level bureaucrats define their work and to a greater extent themselves in terms of relationships with the public. Thus the theory of street level bureaucracy is broad and moves beyond the conventional conceptions of street level bureaucrats' technical sophistication and innovativeness in dealing with ambiguous work settings. It involves relationships and the positioning of the bureaucrats' vis-à-vis the clients and how they perceive themselves in a relationship that is in every detail characterised by unequal interaction between the street level bureaucrats and clients (Kelly 1994; Maynard-Moody and Musheno 2003; Hupe and Hill 2007). The relationships between the street level bureaucrats and the public, according to Hupe and Hill (2007) could be seen as exchanges but not exactly symmetrical ones as there is no balance in the relationship and the clients who could be migrants normally have limited choices.

The arguments by Moore (1987, 1990), Walker and Gilson (2004), Hupe and Hill (2007) and others maintain the basic tenets of street level discretion which emphasise the innovativeness of the street level bureaucrat and the exercise of the discretion thereof in the client – provider interface. The article by Nkosi et al. looks at something more akin to this study, i.e. the dynamics of policy implementation at two South African hospitals. The difference is that, their study looks at the implementation of clear policies (Uniform Patient Fee Schedule and Patients' Rights Charter) while this study looks at a scenario where there is lack of clarity about the position of certain categories of migrants (e.g. undocumented economic migrants) in the policies and directives issued by NDOH and GDOH. This constitutes a policy gap and the street level bureaucrat becomes the key decision maker in dealing with such cases. The decisions made under such circumstances are often informed by attitudes and the context in which they are implemented at a particular and specific point in time. This makes the point that in the absence of clear legislation that applies to undocumented migrants it is essential to understand and contextualise the practice of the health personnel in determining whether to give treatment or not to this population.

2.2.3 The Citizen – Agent Narrative and State – Agent Narrative

Maynard – Moody and Musheno (2000) make sense of street level bureaucrats' work in terms of the "state-agent" narrative, which examine how workers respond to and apply laws, rules, and regulations and the "citizen-agent" narrative which looks at street level bureaucrats as responding to the individual needs and circumstances of citizens or clients. In terms of the citizen-agent narrative the street level

bureaucrats make decisions based on what they think is best for the client and whether the client deserves the provision of service (Maynard-Moody and Musheno 2000). While migrants are not citizens in the strict sense of the word, they would be treated into this category for the purposes of generating an argument that recognises that the street level bureaucrats can sometimes act on behalf of the migrants in circumventing legislation. In terms of their employment street level bureaucrats are agents of the state and excursions into the role of citizen agent are done outside the provisions of protocol. It is important to note that the healthcare providers' behaviour is not always unidirectional as the freedom to bend the rules in favour of migrants can also be a disadvantage to the migrants. The point is that the healthcare providers can use their discretion in actions that put migrants at a disadvantage.

In discussing the relationship between bureaucrats and citizens Hasenfeld, Rafferty and Zald (1987) argue that the street level bureaucrats relate with citizens in at least four ways. These ways are dependent on the type of bureaucracy under scrutiny and include 'the customer, consumer, client, and inmate mode' (ibid: 402). The different types of bureaucratic encounters detailed by Hasenfeld, Rafferty and Zald (1987) are summarised in the following table.

Provider-beneficiary Encounter	Nature of interaction	Applicant's freedom of choice
Customer	Applicant selects the best service provider and providers try to be the best to attract good applicants	High
Consumer	The providers cannot control the input of applicants and are burdened by undesirable applicants	High
Client	Service providers have monopoly over service provision and the applicant has little choice	Low
Inmate	Officials have little official control over eligibility of applicants and citizens use the service as a last resort or when forced to	Low

Table 1: Types of bureaucratic encounters; adapted from Hasenfeld, Rafferty and Zald (1987: 402 – 403)

This study adopts the analogy of the 'client – bureaucrat' mode in which clients (migrants) have little choice over the service provided to them because of the monopoly that the street level bureaucracy has over the particular service (Hasenfeld, Rafferty et al. 1987). In this instance the service concerned is the provision of free primary healthcare which is provided by the public health sector. Street level bureaucrats have discretion in the interaction and could resort to subtle coercive elements in their encounters with clients in a bid to make clients follow organisational procedure or what the street level bureaucrats want. This underlines the domination of the street level bureaucrats in the interaction with migrant patients and the concept of interface analysis is used in this research to conceptualise and understand the nuances of this interaction.

2.3 Interface Analysis

Interface analysis is at the core of understanding the point of interaction between healthcare providers and migrant patients. Long defines the social interface as the, "critical point of intersection between different life worlds…" (2001: 243). Implied in the foregoing is that the circumstances of both the healthcare providers and the migrant patients have a point of convergence and what happens at this point constitutes the linchpin of this study. The point here is that while healthcare providers and migrants constitute two different life worlds (life worlds in this context refer to "the day-to-day world in which the individual lives out his or her life…" (Mayhew 2004) it is not enough to understand their circumstances independent of each other but to appreciate that they influence each other in the determination of what happens on a day to day basis.

The analysis of the interface is a valuable avenue for this study as it yields a deeper understanding of the decisions made by healthcare providers in relation to migrants accessing healthcare and gives an opportunity to access the routine elements of the interaction between the healthcare providers and migrant patients. Drawing on Long's (2001) analogy is plausible to argue that the interface is a simultaneous place of convergence and divergence and therefore allows an open approach to understanding the role and positioning of both the healthcare providers and migrants. Interface analysis allows an excursion into the different perceptions of both the healthcare providers and the migrant patients which effectively helps to understand the decisions they make and the reasons thereof. The concept of interface analysis and street level bureaucracy are used in conjunction with the concept of access to healthcare in interpreting the findings of this research.

2.4 Access to Healthcare

Clark argues that “In its simplest sense, access refers to entry or use of the health care system” (1983:5). Schneider, McIntyre, Birch and Eyles (2006) distinguish between access to healthcare and utilisation of health services. In terms of this approach, access is defined as the exercise of an individual’s free will in the choice and use of a health service. In other terms the concept of access represents ‘the degree of "fit" between the clients and the healthcare system’ (Penchansky and Thomas 1981: 128). This definition implies the availability of the opportunity and freedom to exercise this choice. Access only translates to utilisation if the individual upon sufficient reflection and of his/her own free will decides to exercise his/her freedom to use health care (Penchansky and Thomas 1981; Schneider, McIntyre et al. 2006). In terms of this conceptualisation, access does not only constitute the decision by the health user to go to a health institution but inculcates the availability of the service to the user. Schneider et al (2006) opt for the understanding of access in terms of the market forces of demand and supply. In their argument they posit that the issue of access could be seen as a dynamic interaction between the supply side (represented by the health system) and the demand side (represented by households or individuals). In terms of this understanding the individual looks into their resources and rationalises based on a cost benefit analysis and comes up with the decisions to either seek healthcare or not (Schneider et al’s model is summarised in figure 1). While Schneider et al (2006) use the household as their unit of analysis, it is important to note that for the purposes of this paper the individual is used as the unit of analysis. The decision to use the individual as the unit of analysis is informed by the nature and characteristics of most migrant households in Johannesburg. Research has shown a significant presence of single member households in the inner city of Johannesburg (Vearey, Nunez et al. 2009).

Access can be summarised into more specific areas of fit between the healthcare system and the clients (Schneider et al 2006, Penchansky and Thomas 1981). These are what Penchansky and Thomas call, the dimensions of access and they include availability, accessibility, affordability and acceptability. In terms of this understanding, availability refers to the adequacy of services relative to the healthcare needs of the user. Accessibility refers to physical access, i.e. the proximity of the health institution to the health user. Affordability refers to financial access, whether the health service is appropriately priced to match the individual's capacity to afford it. Acceptability refers to cultural access and relates to the interaction between the service providers and the users of the healthcare facilities. It is cultural because it draws from the circumstances that the healthcare providers and patients bring to the interface. According to Penchansky and Thomas acceptability refers to

> The relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients... In turn, providers have attitudes about the preferred attributes of clients or their financing mechanisms. (1981: 129).

Access to health services is a key concept in this discussion and for the purposes of this study the fourth variant of access shall be at the centre of analysis. Acceptability or cultural access becomes more important in the South African public health system because of the presence of cross border migrants. The interaction between this segment of the population and the healthcare providers is in every way permeated by the discourse of culture and language. This is discussed in the context of certain entitlements and rights that migrants have with respect to accessing healthcare in the public health system. The crucial element of Schneider et al's conceptualisation of cultural access is the reference to

the healthcare providers' and patients' attitudes towards and expectations of each other. This captures the focus of this study and helps in the unpacking of the interaction between migrants and healthcare providers and how this features in the broader discussion on migrant access to healthcare.

In terms of the analogy represented in the work of Schneider et al it is important to look closely and conceptualise the relationship between migrants and the health providers in terms of access to healthcare. The point here is to understand the elements in the behaviour of the healthcare providers and their migrant patients which amount to the curtailing of healthcare access by the former. Of importance is to look into the role played by cultural difference and the possibility that difference could be constructed and how this construction could impact on the behaviours of both migrants and healthcare providers. The key question to ask is: to what extent does culture influence the behaviour of healthcare providers in a way that could curtail or provide an enabling environment for the migrants to exercise their choices. This analysis broadens access to include even circumstances beyond the health facility that could impact on the behaviour of the migrants and healthcare providers. It also helps in understanding the elements of the institutional culture of the healthcare institution that can explain the healthcare providers' behaviour towards patients in general and migrants in particular.

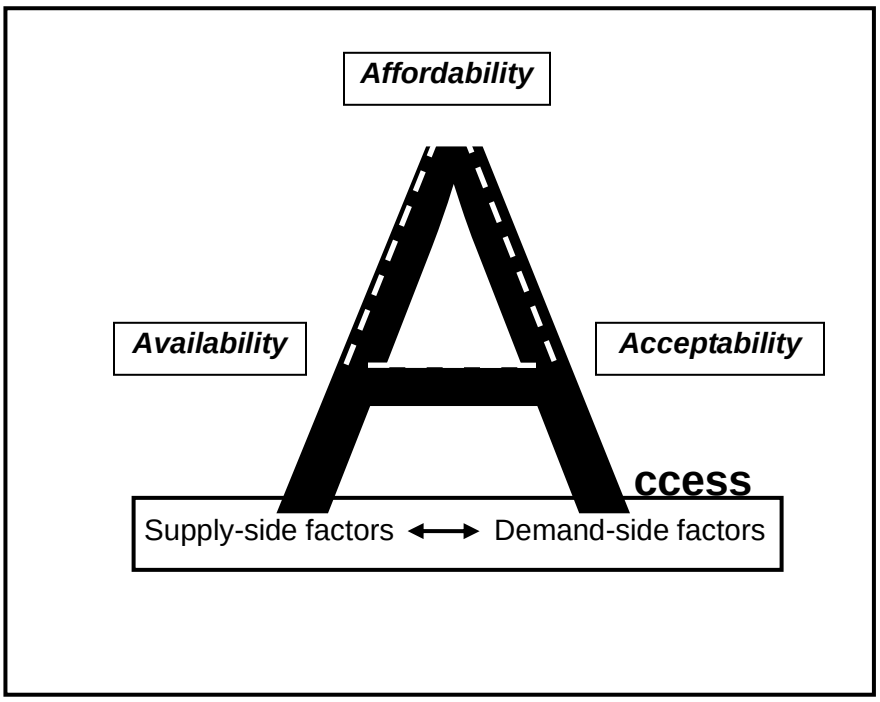


Figure 1: Conceptual framework on access to healthcare (Schneider, McIntyre, Birch and Eyles (2006: 5)

2. 5 Summary and Main Argument of Research

The literature detailed by Lipsky (1980); Moore (1987, 1990); and Walker and Gilson (2004) accounts for the politics of street level bureaucracy in which the street level bureaucrats rationalise their behaviour and creatively interpret the policies made at levels high up in the hierarchy. The argument by Lipsky (1980) is that the street level bureaucrats have agency and do not necessarily accept decisions handed down by the hierarchy as given. This argument creates an understanding of the work that the frontline health care providers are engaged in and helps in the understanding of the discretion that they have in making decisions in cases where the migrants are undocumented. Often the decisions they make are contrary to the policies imposed or they have a touch that is not accounted in the repertoire of the senior level management. This is captured in Lipsky's argument that "the practices (i.e. coping mechanisms and circumventions) of street level bureaucrats effectively become public policy rather than the intentions or objectives of documents and statements developed at a central level" (1980: xi). It is plausible to argue that the foregoing is more akin to a depiction of a collision course or conflict between senior level management and subordinate or frontline staff. This is played out in the disjuncture in terms of what is decided and put on paper and what actually happens on the ground, as it is often the case that policy formulators are not necessarily the policy implementers. Policy formulation and policy implementation are not a matter of supply and demand but involve a crucible of factors that mediate and often alter the relationship between the bureaucrats and the clients. In other words there are backward and forward linkages between the street level bureaucrats and their clients as the attitudes of the staff are often informed by the behaviour of the patients and vice-versa.

The analogy and understanding of street level bureaucracy detailed in the foregoing is important in the unpacking of the decisions and nuances attendant to the behaviour of healthcare providers in relation to migrant patients. However it does not go beyond the comprehension of the innovativeness of the street level bureaucrats in circumventing complex and often ambiguous policies. This study infuses the conventional understanding of street level bureaucracy with a focus on situations where policies are inadequate or absent in relation to specific groups such as undocumented migrants. In this regard the understanding of street level discretion and facility level discretion is taken into account in a bid to unpack the attitudes and behaviours of street level bureaucrats that present themselves as barriers to the migrants' accessing health care. This line of thought is informed by the often conspicuous absence of a clear code and policy that informs the treatment of undocumented migrants; a scenario that leaves the health workers in a particularly precarious position of having to use their own discretion to decide whether to give health care or not. The discretion of the health personnel implies a certain level of power and therefore the concept of street level bureaucracy allows the research to document and analyse the role of such discretional power in the determination of health care access by migrants. The lack of clarity in the policies often leads to 'a culture of discretion' that Kelly (1994:121) defines as a situation in which individual beliefs have a bearing on the implementation of policy at the street level. A culture of discretion decimates the resources and the little power that the undocumented migrants can utilise to better their position in relation to the street level bureaucrats.

Chapter 3: Research Methods

3.1 Introduction

To capture the nuances of the client - provider interaction and make sense of the circumstances that the healthcare providers and migrants bring to the point of interaction the research had to utilise the complementary strengths of the different methods of qualitative research. The data was gathered through non participant observation, participant observation, informal and formal interviews, conversations and focus group discussions. An understanding of what happens at the point of interaction between migrants and healthcare providers is crucial in advancing the argument that the healthcare providers and migrant patients have some measure of influence on each other's behavior. The interaction between the healthcare providers and migrants could be seen as contributing to the decision making process by the former. The different methods used in the research help in the collection of relevant data and attempts at answering the research questions. To a considerable extent the research relied on observational methods, specifically participant and non participant observation. In addition to the methods, this section also presents the summary of the research process, the study population, data analysis, ethical considerations and limitations of the study.

3.1.1 Study Site

The study focused on the provision of healthcare to a specific population (migrants) and for this reason it had to be conducted at a facility that is in close proximity to migrant dense areas. Hillbrow Community Health Centre fitted the profile because it is a public healthcare institution that provides free primary healthcare services and is located in a predominantly migrant area. It has also been at the centre of reports alleging denial of access to healthcare for migrants (HRW 2009b, MSF 2009).

3.1.2 Summary of the Research Process

Permission to conduct research at the Hillbrow community health centre was granted by the facility manager after the non medical ethics committee of the University of the Witwatersrand had approved the study protocol (number HO 90808). The facility manager introduced the researcher to the chief clerk and tasked the chief clerk with the responsibility of introducing the researcher to the frontline healthcare providers. The researcher was introduced to the healthcare providers as a student and the nature and purpose of the research explained to all the frontline healthcare providers.

The research process involved the researcher going into the health centre over a period of about 3 months. The fieldwork started at the end of September and lasted up to the beginning of December 2009. The researcher made a total of 31 visits to the community health centre during the 3 months period with each visit ranging from 2 to 5 hours. During the initial stages of the research, the researcher would alternate between sitting at the front desk and making observations on the interaction between

frontline healthcare providers and patients and conducting interviews with the frontline healthcare providers in the back room. After a field day the researcher would write up and reflect on the data collected, and plan for the next field visit. The planning involved specifying the kind of data to collect and questions to ask.

Days of the week also played a part in the scheduling of appointments with the frontline healthcare providers. Mondays, Tuesdays and Thursdays are busy days and would be earmarked for observations while Wednesdays and Fridays would be utilised for interviews. On Mondays, Tuesdays and Thursdays the researcher would go to the health centre at 8 am or 9am and leave at around 11 am or 12 pm when the pressure had subsided. On Wednesdays and Fridays the researcher would go in the afternoon (around 12pm) and leave at 4pm when the institution closes. These times were not fixed but varied from day to day depending on the circumstances at the community health centre. The healthcare providers shared that Mondays and Tuesdays are busy because the health centre closes on weekends and Thursday for some reason has a lot of patients who are domestic workers. The frontline healthcare providers have even named Thursday 'Sheila's day' because most of the domestic workers come to the health centre on Thursday.

The study suffered a reactive change in attitude by the frontline healthcare providers upon discovering that the researcher is a Zimbabwean migrant. The researcher speaks fluent Zulu and has good understanding of Setswana, and the staff could not tell whether he is South African or not until they asked about his place of birth. The initial phases of the research showed a much more frank representation of the opinions and experiences of the service providers in their interaction with migrants. The latter stages showed a much more controlled and pensive response to the presence of the

researcher. The frontline healthcare providers changed the way they spoke about migrants from a much more honest resentment of foreigners to a much more tolerant attitude. Participant observation and interviews with migrants became important in attempts to overcome the gap created by the change in the frontline healthcare providers' attitude.

After the first week of fieldwork the researcher had a briefing with the supervisor to reflect on the initial findings and discuss emerging themes. The discussions were held on a regular basis to explore possible ways to elicit more data from the research process. The fieldwork was followed by the full fledged data analysis and initial writing of the thesis.

3.2 Research Participants

3.2.1 Frontline Healthcare Providers

The primary unit of focus in this study has been the frontline healthcare providers at the Hillbrow Community health centre. In general terms, healthcare providers constitute the individual practitioners, groups of practitioners or facilities e.g. clinics, hospitals, or other institutions (Hansom and Berman 1998). In specific terms and recognising that the category of healthcare providers is a broad one, there is

need to clarify that the frontline healthcare providers that are referred to in this research are those that work at the front desk, i.e. the community health centre clerks and other personnel responsible for the registration of patients at the centre. The front desk is an important component of the community health centre structure as it is the entry point to the institution. It is at this level that most of the decision making takes place on whether the migrant client accesses the health centre or not. The front desk personnel are constantly referred to as the street level bureaucrats throughout the research primarily because of the tasks that they execute at the point of intersection with patients.

3.2.2 Cross Border Migrants

The other important group that participated in this research were the cross border migrants. The research initially targeted the undocumented section of this group due to the precarious nature of their position at the point of interaction with frontline healthcare providers. However as the research progressed this category was collapsed into the more general one of cross border migrants as documentation seemed not to be an important determinant in the decision making by the frontline service providers. The researcher could differentiate between South African nationals and migrants by listening to patients' responses when the frontline healthcare providers asked questions about their nationality. Migrant characteristics and attitudes are important in understanding the decisions made at the front desk and play a part in the way that they approach the interface with the street level bureaucrats and have potential to determine whether they gain access to healthcare or not.

3.2.3 NGO Healthcare Providers

In addition to the frontline healthcare providers and migrants, the researcher had discussions with staff from MSF[13] in an attempt to explore the challenges of access further and thicken the understanding of what constitutes everyday practice at the interface. MSF maintains a database of patients[14] who have been rejected at the community health centre and the bias in their perspectives provides an interesting conceptualisation of the interface. The research also took advantage of a discussion at a Migrant Health Forum meeting lead by the Forced Migration Studies Programme (FMSP) to explore the training needs of healthcare providers that deal with migrants. The NGO service providers are an important group primarily because they deal with migrant patients and their views as outsiders to the system help in exploring the different perspectives about those that are inside. I classify NGO service providers as outsiders because they are not under the direct control of government and are also not part of the Hillbrow Community Health Centre establishment. Those that are inside are the healthcare providers that work at Hillbrow Community Health Centre and represent the public healthcare system.

[13] Médecins Sans Frontières / Doctors Without Borders (MSF) is an international humanitarian medical aid organisation, created in 1971 as a response to a humanitarian crisis in Africa. MSF in Johannesburg speaks out about medical and humanitarian crises faced by vulnerable communities by sharing information with the South African public, the media, government agencies and other NGOs. MSF runs a clinic next to the Central Methodist Church in central Johannesburg. The clinic provides basic primary healthcare to the migrant population resident at the central Methodist Church. The majority of the community they serve is Zimbabwean in general and Shona speaking in particular (http://www.msf.org.za/pages.php?p=5).

[14] The researcher was denied access to the database for reasons of the confidentiality of the information

3.2.4 Selection of Participants

The research relied on a purposive procedure in identifying the participants which Legard, Keegan et al. (2003) describe as a process of selecting participants driven by research findings as they develop. The researcher would simultaneously collect and analyse data and constantly compare data and its possible meanings by using the developing analysis to decide what data to collect next and from where to get that data (Legard, Keegan et al. 2003). This meant that the researcher not only selected people with relevant experience (key informants), but also selected relevant events, locations and times of day as necessary to collect data.

3.3 Research Instruments

3.3.1 Observation

> "Observation is at once the most primitive and the most modern of research techniques as it develops from the most casual experience with a subject to the most formalised, abstract measurement of variables by the use of precision instruments" (Goode and Hatt, 1952: 119)

The research made use of non participant and a limited degree of participant observation. Non participant observation refers to a research technique whereby the researcher watches the subjects of his or her study, with their knowledge, but without taking an active part in the situation being studied (Hammersley and Atkinson 2007; Fabian 2008). Participant observation on the other hand denotes a practice where the researcher assumes a role within the research context and participates in some way and in this study, the researcher often pretended to be a patient for reasons that are discussed in this section (p.46). The method of observation is essentially ethnographic but it is important to mention here that despite having some elements of ethnography, the study could not be distinctly categorized as ethnographic. Ethnography does not have a standard definition but could be referred to as involving a researcher who participates

> "overtly or covertly in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artifacts" (Hamersley and Atkinson 2007: 3).

The elements of ethnography go as far as the attempt by the research to construct and represent everyday reality and capturing the mundane moments of decision making by the frontline healthcare providers in dealing with the migrant patients. Such moments could only be captured through trained and purposeful observations because of the nature and context in which they take place. The point here is that it is these kind of interactions that are taken for granted yet they reveal the intricacies of the street level bureaucracy and the repertoire from which the frontline healthcare providers draw the resources to deal with their clients. Silverman argues that

> the fundamental logic of social science observation is in comprehending and making sense of the mundane rather than the exciting (1993: 31).

It is in the routine elements of the street level bureaucrats' work that the research was able to understand the effects of their frustration with the working conditions at the health centre, and how these influence their behaviour at the frontline.

Observation contrasts with the research interview in that it focuses on naturally occurring activities and therefore surpasses the richness of the research interview (Silverman 1993). The observation in this instance was not limited to the front desk but included all interactions that the researcher could observe. These included interactions with both documented and undocumented migrants, citizen and non citizen patients, and incidents that could play a part in the decision making such as arguments between staff and patients. This was done in order to understand the modus operandi of the frontline service providers and provide space for a comparison in the treatment of different categories of patients with or without documentation. The decision to generalise observations was also informed by the fact that documents are not a prerequisite to accessing healthcare at the health centre. This meant that it

became difficult to distinguish the documented from the undocumented at the front desk as migrants would produce documents only when the healthcare providers needed some clarity of sorts.

The research allowed space for flexibility on the part of the researcher and enabled some timely shifts between covert and overt observation of street level behaviour patterns. Covert observation refers to the conduct of research in which the participants are not informed about the reasons of the researcher's presence[15]. Overt observation denotes a situation where the researcher is open about the purpose of their presence in the field. The researcher would sometimes go into the community health centre and sit on the chairs allocated for patients without any of the frontline healthcare providers noticing. This was done in order to gain the fuller picture of events beyond what the pensive street level bureaucrats could divulge. Such moments of unobtrusive observation allowed the researcher to claim back the power that had been ceded to the frontliners in briefing them about his presence in the initial stages of the research and have control over what is observed rather than having the health providers control what they would want the researcher to observe. This was done to curtail participants' reactivity to being observed and subsequently altering their behaviour in a process similar to the 'Hawthorne Effect'[16]. Participants in research projects have been observed to alter their behaviour to conform to what they think is appropriate for the researcher to see (LeCompte and Schensul 1999). The urge to alter behaviour as a result of the research is minimal when the participants do not see or experience the researcher's intrusion but becomes more when they see the researcher and are aware of his/her

[15] http://wps.pearsoned.co.uk/ema_uk_he_plummer_sociology_3/40/10342/2647687.cw/content/index.html Accessed 2010-02-01

[16] The Hawthorne effect describes a situation where the participants may alter their behavior due to the attention they receive from researchers rather than because of any particular experimental manipulation. This effect was first discovered and named by researchers at Harvard University who were studying the relationship between productivity and work environment at the Hawthorne Works plant of Western Electric. http://psychology.about.com/od/hindex/g/def_hawthorn.htm

presence and intrusion into their space. Arguing in favour of non obtrusive observation, Van der Geest and Sarkodie (1998) posit that in cases where participation in the ordinary sense is not possible the fieldworker may opt for covert forms of observation in which those who are being studied are not aware of the fieldworker's presence because the latter pretends he/she is one of them. In the case of this study the researcher drew cover from the patients that were in the queue and easily passed as one of them without the staff noticing and actually not paying attention. Oscillating between covert and overt observation provided the study with a platform to explore and compare the data shared by the participants and ascertain the extent to which what they shared was indeed happening. The frontline healthcare providers were informed about the researcher's presence at the community health centre in accordance with the provision of ethics protocol.

3.3.2 Field Notes

> The field note occupies the intellectual space where reading, writing, and ethnographic interpretations meet (Atkinson, 1992: 6)

After leaving the field the researcher would often sit and think through the activities and interesting incidents of the day and put them into writing in the form of field notes. The field notes data was constituted by observations and informal conversations which could not be written during the fieldwork due to the fear of obstructing some naturally flowing conversations. According to Atkinson (1992) field notes are the texts that a researcher constructs in an attempt to produce day to day accounts of the

social life that they have observed and participated in. What constitutes data in the researcher's field notes is somewhat the result of sieving and winnowing efforts to produce what is writable and readable. Field notes together with conversations form the core of the data that relates to the nuances of the street level bureaucrats interaction with migrants. They provide the resources for an informed analysis of the events and reality that obtains at the street level. However this is not to drive this research into the trap of textual fundamentalism which Fabian (2008) warns against. The argument is that the text should not become the foundation or basis on which conclusions about a specific phenomenon are drawn (Fabian 2008). In this case it would be unfair and quite illogical to base conclusions on a partial representation of reality. Texts that constituted the field notes were generated from the perspective of the researcher and from the researcher's own experience of reality. Therefore they reflect the experiences of the researcher and what the researcher could reconstruct after a field day. Writing field notes at the end of each day meant that the memory of major incidents and crucial conversations was still fresh in the mind of the researcher and allowed a documentation of the key points that inform the findings of the study. The major disadvantage in this process was the inability to write down some interesting points during conversations with the staff so as to maintain the flow of the conversations and avoid unnecessary interruptions. Writing down points during conversations could have raised suspicions and led to the urge by frontline health providers to withhold information or limit the freedom with which they expressed themselves.

3.3.3 Interviews

The research made use of unstructured, formal and informal interviews with key informants and HCHC management. Citing Denzin (1970) Silverman argues that observation is often criticised for focusing too much on the current and neglecting the history and events that occurred before the observer entered the scene. Interviews played a part in overcoming the shortcomings of observation that are highlighted by Silverman and data from interviews provided a window of insight into the thoughts of the participants together with the circumstances from which they draw their experiences (Hammersley and Atkinson 1983). The interviews were guided by the approach advocated by Hammersley and Atkinson (1983) that conceives interviews as social events in which the researcher and the researched are both participant observers and the outcome of the research process is in every respect a result of their interaction. In this regard, interviews ranged from spontaneous, informal conversations to formally arranged meetings with health centre management and MSF staff (Hammersley and Atkinson 2007).

The first round of interviews for this study was general and included 7 frontline healthcare providers (4 female and 3 male), and 1 female member of staff who assists with the registration of patients during periods when there is a lot of pressure. The questions asked during this phase were general and included issues about the nature of work and the type of clients that the frontline healthcare providers attend to at the community health centre. This phase of interviews was completed during the first week of the fieldwork, i.e. 22 to 28 September 2009 and was characterised by openness on the part of the frontline healthcare providers. The second phase targeted those that had been forthcoming during the initial interviews and seemed more willing to share information with the researcher. Those that were included in this phase would often talk at length in response to the questions that were asked as

opposed to those that showed open hostility and would sometimes not respond to certain questions. It is important to mention that the information that was gathered during the second phase was more in depth and to a larger extent answered some pertinent questions guiding this research. The third and final phase of interviews at the clinic targeted the management of the institution to explore some of the themes that had arisen during the initial stages of the research. During this phase the researcher would also go back to the frontline staff to seek clarification and further information on certain issues in the research.

The fourth and final phase of the interviews targeted the undocumented and documented migrant patients that had been denied or granted access to treatment at the institution. This was done as a way of getting the perspective of those that had gone through the different levels[17] of the system. It allowed the research to gain insight into the reasons that they cite as informing the decisions of the street level bureaucrats to provide or deny them what they are entitled to. A total of 5 interviews were conducted with migrants (2 at the Hillbrow Community Health Centre and 3 at the Central Methodist Church (CMC) where access was secured with the help of the MSF). Fortunately the fieldwork for this research coincided with a 3 weeks long survey by the MSF to ascertain the challenges that migrant patients, especially refugees and asylum seekers encounter in the public health system in and around the Johannesburg inner city. During this phase the researcher also had interviews with 2 staff members from the MSF to get their perspective on issues that affect migrants and hear their experiences in dealing with the public health system.

[17] By levels of the system the research refers to the movement of patients from one department to the next, e.g. moving from the front desk to the consulting rooms where they are served by nurses or doctors

3.3.4. Focus Group Discussion

The research utilised the focus group discussion (FGD) method which is a group discussion of approximately 6 - 12 persons guided by a facilitator, during which group members talk freely and spontaneously about a certain topic.[18] Three focus group discussions were conducted during the fieldwork; one with the health providers at the Hillbrow Community Health Centre during the initial stages of the research, another with migrants residing at the CMC towards the end of the fieldwork and the other with members of the Migrant Health Forum in Hillbrow. The group discussion with the health providers was not the common type that is planned and a participant informed in advance and invited to participate but was more of a spontaneous endeavour or rather a focus group of convenience. The researcher took advantage of a lunch break by the frontline staff at the health centre and converted the discussion into a purposive conversation where questions would be asked and topics brought up for discussion. This encouraged the staff members to speak up about their experiences with migrant patients and their general conditions of work without making reference to their specific and individual circumstances. The discussion created an atmosphere of de-individuation and elevated the spirit of 'us rather than me' with the result that the health providers spoke more as a collective rather than as individuals. The purpose of the discussion was to obtain in-depth information on concepts, perceptions and ideas of the health providers as a group and in their own space separated from the presence of patients.

[18] http://www.idrc.ca/en/ev-56615-201-1-DO_TOPIC.html

The other focus group discussion was conducted with members of the migrant health forum and was coordinated by the FMSP[19]. The FGD was organised as part of the consultative process to determine the training needs of healthcare providers in dealing with migrants[20]. The data generated from the FGD provided valuable information and insight into the reality of what happens at the interaction between migrants and frontline healthcare providers. This was followed by another FGD at the central Methodist church in Johannesburg with respondents who had previously sought healthcare at the Hillbrow community health centre. The focus group discussion was coordinated with the help of staff from the MSF clinic adjacent to the central Methodist church. The focus group at the central Methodist church discussed and elicited information that could not have been gathered from observations and conversations with the frontline staff at Hillbrow community health centre.

3.3.5 Conversations

How the research proceeds often depends on the research questions, the circumstances and the participants in the research process. Having fruitful conversations likewise depends on the circumstances characterising the nature of engagement and the participants that you are engaging with. Conversations could be oral inquiry processes, collaborative conversations or long and serious conversations (Feldman 1999). The researcher utilised conversations with the frontline staff to get their perspectives on certain day to day issues. This was done during times when the researcher sat at the front desk and took the opportunity to listen to the conversations that the frontline healthcare

[19] The FGD was facilitated by Marlise Richter with the help of this researcher
[20] The discussion yielded some information that is relevant to this research.

providers had amongst themselves and with colleagues from other departments. Listening to conversations allowed the researcher to gain an understanding of the nature of the relationship that the frontline healthcare providers have among themselves and with other sections of the institution.

3.4 Data Analysis

'Data analysis creates the chunks of data that portray what the researcher discovered' (LeCompte and Schensul, 1999: 2) and interpretation does the explanation and answering of questions that the researcher and non researchers ask regarding the behavior of participants. To this end, the research engaged in interim analysis, thematic analysis and comparative analysis.

3.4.1 Interim Analysis

Data processing and analysis in qualitative studies that use observation and interviews are ongoing processes because variables are not identified prior to data analysis (Pope et al. 2000; Guion 2001; Becker 1971). The researcher often sat down and read through field notes and interview data soon after a day's fieldwork with the purpose of expanding and organising the fieldwork data. Analysis is an important step and involves determining the meaning in the information gathered in relation to the purpose of the study (Guion 2001). During the ongoing process of analysis the researcher would identify themes, commonalities, and patterns to make sense of the information and engage in a thematic organising of the data. The themes on which the analysis was based emerged from the field and were collated with the research questions and objectives of the research so as to keep sight of the original assumptions (Pope, Ziebland et al. 2000). This ongoing or 'interim analysis' procedure allowed the researcher to identify gaps in the data gathering process and ensured that only the relevant information was collected. According to Pope, Ziebland et al. interim analysis allows "the researcher to go back and

refine questions, develop hypotheses, and pursue emerging avenues of inquiry in further depth" (2000: 114). The ongoing analysis of the data informed the decision to schedule the research into phases that allowed the researcher to make informed choices in selecting the key informants for the second round of interviews with the frontline staff.

3.4.2 Thematic Analysis and Comparative Analysis

Interim analysis is closely related and works with **thematic analysis**, which is "highly inductive, i.e. the themes emerge from the data and are not imposed upon it by the researcher" (Tere 2006). Thematic analysis was done simultaneously with data collection to keep track of emerging themes, and as posited by Tere (2006) the analysis could be augmented by background reading, to explain emerging themes. **Comparative analysis** was also used to analyse and make sense of the interview data from the health providers and undocumented migrants. Tere (2006) argues that, when using comparative analysis, the researcher compares and contrasts data from different participants and the process continues until the researcher reaches a point of satisfaction that no new information is being generated. For the purposes of this study the data from interviews and observations was preserved in its textual form and indexed to generate comparative analytical themes and theoretical explanations that would illuminate the discussion on the social interface between frontline healthcare providers and undocumented migrant patients.

3.5 Ethical Considerations

Ethical research practice refers to values and rules of conduct in research and consultation. Bulmer (1982) argues that the scientific community has responsibility not only to the ideals of the pursuit of objective truth and the search for knowledge, but also to the participants of their research. The researcher has to always take account of the effects of his actions upon the subjects and act in such a way as to preserve their rights and integrity as human being (Bulmer 1982). Eide and Kahn (2008) argue that qualitative research, unlike the natural sciences by its very nature makes it impossible to take a stand point divorced from the subject of the research as is the case in physics, biology and chemistry. In qualitative research "the standpoint is mutual, researcher to participant, human being to human being" (Eide and Kahn 2008). The front desk creates space for close encounters and interaction between the researcher, the staffs and migrants and must therefore be handled with utmost care and adherence to ethical procedure.

The research followed ethical procedure first by applying for ethical clearance from the non – medical research ethics committee at the University of the Witwatersrand protocol number HO 90808 (see appendix 2). Ethics clearance was a requirement at the institution in order to gain permission for the study. In accordance with the principles of ethical research, the researcher had to reflect on the risks that the participants could be exposed to and safeguard the interests and safety of the participants (Burgess 1984). The frontline staff agreed to openly share their experiences with the researcher because he had promised that the data would be used for educational purposes and their names would not be included in the research report. To this end the names of the participants were changed so as to

maintain their anonymity and protect them from undue retribution by management and readers of the research. Some of the information that was shared is sensitive and touches management practices and if the names of the informants are divulged this could lead to unfair treatment or even job losses at the hands of management. The names of the migrant patients who participated are not included in the data and where necessary pseudonyms have been used. Like the frontline staff, they shared some sensitive information that includes the names of health providers that have treated them badly, and it constituted the duty of this researcher to protect their interests and maintain confidentiality.

The entire research process was conducted in an ethical manner, guided by Burgess's (1984) observation that ethics is a matter of principled sensitivity to the rights of others. In addition to seeking permission from institutional management, the researcher informed the participants about the nature and conducts of the study and gave them adequate opportunity to reflect and make the decision either to participate or withhold their co-operation. This undertaking is in line with Burgess's (1984) argument that, as far as possible research should be based on the freely given informed consent of those studied. Informed consent, according to Burgess implies a responsibility by the researcher to explain as fully as possible, and in terms meaningful to participants, what the research is about, and why it is being undertaken. As affirmation that they had understood the nature and conduct of the study, the participants were asked to sign a written informed consent form that accompanied the participant information sheet which included contact details of the researcher.

3.6 Limitations of the Study

The study could have illuminated the discussion on street level bureaucracy and migrant access to healthcare in a more pronounced way if it were to be wide scale and not limited to one institution. Time constraints and the volume of work involved in embarking on a wider and comparative study limited this study to a single institution. Though limited in its reach, the study provides the more important lens through which the social interface can be comprehended and theorised in relation to health access by cross border migrants. The study was also limited to the frontline healthcare providers and as such observations could not be made on the interactions involving patients and other healthcare providers such as nurses and doctors. Research at this level could have highlighted some of the challenges that migrants face once they have gone past the front desk. Perspectives on the interaction beyond the front desk were drawn from interviews with migrants and lacked the comparative dimension which could have included the perspectives of the nurses and doctors. Drawing from the above discussion it is worth noting that the researcher as a migrant also brought certain biases into the interface between migrants and healthcare providers. These biases placed the researcher as an insider to the migrant community and an outsider to the hospital establishment. The intercalary position of the researcher as both an instrument and the hand behind the instrument in the research process did not however disqualify sound judgement but allowed a reflective gaze on the part of the researcher. Long and Long (1992) underscore the importance of treating the researcher him or herself as an active social agent who seeks to understand social processes through entering the life worlds of local actors who, in turn, actively shape the researcher's own fieldwork strategies, thus contributing to the final outcome of the research process itself.

3.7 Conclusion

The complementary strengths of different methods ensured that the research gathered data that is not only relevant but rich and timeous. The weakness of observation as ahistorical was overcome by the strengths of the interview method which delved into issues that could have happened prior to the researcher entering the field. At the same time, the limits of the interview were overcome by periods of unobtrusive observation which curtailed the effects of reactivity to the researcher and the research instruments. The challenges of researcher identity and foreignness had to be dealt with in a sensitive manner that involved a variation of research techniques and maintenance of a sizable amount of objective analysis. In essence, the researcher had to take a step back and let the research process unfold in order to limit moral judgements at the interface.

The following chapter is the result of the triangulated qualitative methods employed during the course of the research. The research relied more or less equally on observational methods and interviews with both migrants and healthcare providers to create a comprehensive understanding of the interface.

Chapter 4: Presentation of Findings

> "Documents are not a requirement here, we treat everyone regardless of whether they have documents or not…. We only ask for documents in cases when the patient does not speak any of the South African languages and we need to get the spelling of their name right" (HCHC interview 30/09/2009)

4.1 Introduction

This chapter discusses the behaviour and conduct of the frontline healthcare providers at the community health centre. The data is drawn from observations and interviews with both frontline healthcare providers and migrant patients. The discussion is guided by the need to have a detailed understanding of the interface and the circumstances that inform the frontline healthcare providers' decisions in dealing with migrant patients. The chapter combines the views of frontline healthcare providers and migrants as well as some NGO service providers who have had experiences with the Hillbrow community health centre system. The inclusion of the views of NGO service providers and migrants creates the background against which the work and decisions of the street level bureaucrats is contrasted and further understood. The discussion is informed by the idea that what counts as everyday practice at the front desk is in every respect the result of the "accumulated social experiences and culturally acquired dispositions of the actors involved"(Leeuwis, Long et al. 1990). To this end, the

chapter looks at the background, location and scope of services provided at the Hillbrow Community Health Centre, the profile of migrants, the structure and context of street level work at the community health centre and factors influencing street level decision making.

4.2 Context and Location of Hillbrow Community Health Centre

4.2.1 Hillbrow Suburb

Hillbrow is part of the Johannesburg Inner City which forms part of the Region 8 (F) administrative area (City of Johannesburg 2004). The region is centred on the traditional Central Business District of Johannesburg. It includes Yeoville, Bellevue, Troyeville, Jeppestown and Berea to the east. To the west, it stretches to include Pageview and Fordsburg (CoJ 2004). Hillbrow was established in the late 19th century as a middle class white residential area (Silverman and Zack 2008; Morris 1999). It remained a white only area until the mid 1970s when coloureds and Indians began to move into the area, replacing the white residents who were moving out due to the rise in rental costs and a drop in suburban housing prices (Morris 1999; Grobbelaar 2005). The number of blacks in Hillbrow remained limited until the 1990s due to the apartheid government's influx control laws which required blacks to carry a pass (Grobbelaar 2005). In a reflection of the changing political environment in South Africa Wooldridge (in Grobbelaar 2005) notes that the number of blacks rose from about 10% in 1985, to 62% in 1993 and approximately 80% in 1996. The area has deteriorated over the years, from an attractive and well maintained suburb before the 1990s to decaying high rise apartments in the post 1994 period(Silverman

and Zack 2008). The urban decay in the area has been the result of poor planning to accommodate a rapid rise in the black population due to both local and cross border migration, and lack of investment in the properties (Grobbelaar 2005; Silverman and Zack 2008). Hillbrow is now well known for its high levels of unemployment, poverty, crime, and has a population density that averages 65 132 people per square kilometre, making it one of the highest in Africa (Richter 2008). The area has also assumed a more cosmopolitan appeal as it is home to different kinds of migrants including South Africans, Zambians, Nigerians, Zimbabweans, Angolans, Mozambicans and Congolese amongst many other nationalities.

4.2.2 Hillbrow Health Precinct

Hillbrow community health centre is located in the Hillbrow Health Precinct[21] which consists of the area between Constitution Hill to the north, Joubert Park to the south, Braamfontein and the Metro Centre to the west and Hillbrow suburb to the east. The health precinct is bordered by Kotze Street in the north, Smit Street in the south, Klein Street in the east and Joubert and Rissik Streets in the west. The Hillbrow Health Precinct (HHP) has the following facilities[22];

- Hillbrow Community Health Centre which is a Gauteng Department of health facility

[21] The place was formerly known as Hospital hill
[22] Johannesburg Medical Quarter Business Plan Draft 1 August 2005

- Esselen Street Clinic which is a City of Johannesburg health facility that also serves as an important HIV/AIDS and reproductive health research and training facility for Wits University's Reproductive Health Research Unit (RHRU)
- National Health Laboratory Services
- National Council for Occupational Health
- Johannesburg Medical-Legal Centre
- National Blood Transfusion Services
- The old Hillbrow Hospital
- The 100-year-old Hugh Solomon building on the corner of Klein and Esselen streets.[23]

4.2.3 Scope of Services Provided At the Hillbrow Community Health Centre

The Hillbrow Community Health Centre (CHC) provides a range of services, including: family planning, ante-natal and post-natal services, termination of pregnancy; home-based care; medical and legal facilities to tackle child and sexual abuse, and domestic violence; physiology and radiology; maternity and obstetrics; mother and child health; 24-hour casualty services and minor theatre; a polyclinic and

[23] **Tom Mapham** World-class health facility for Hillbrow Sunday Times (Johannesburg) - June 26, 2005

outpatient services; psychology; Dental care; Mental ward; Rehabilitation (Occupational Therapy & Physio Therapy); TB clinic; ART clinic, Yellow block.

Hillbrow Community Health Centre used to be Johannesburg General Hospital[24] and was officially opened with 103 beds on the 5th of November 1890 (Grobbelaar 2005). Johannesburg General Hospital was moved to Parktown in 1968 and the facility in Hospital Hill continued to function as Hillbrow hospital until December 1997 when it was changed to a community health centre with some of the infrastructure being decommissioned (HHP Business Plan 2004). Hillbrow health centre is a much bigger establishment and acts as a referral centre for smaller clinics in the inner city. Being a Community Health Centre (CHC)[25] it is neither a hospital nor a clinic but occupies the level between small hospitals and conventional clinics[26]. It differs from both by the scope of services that are available. The absence of wide ranging in-patient care distinguishes it from hospitals and the presence of a wider scope of primary healthcare services and some specialist services separates it from clinics.[27]Owing to the wider scope of services, HCHC draws clients primarily from Hillbrow and proximate suburbs such as Yeoville, Berea, Joubert Park and Central Johannesburg. Some clients come from as far as Soweto in the south western parts of Johannesburg and Boksburg in the east rand.

[24] Now Charlotte Maxeke

[25] A community health centre is defined as a facility that, in addition to a range of other PHC services, normally provides 24 hour maternity and accident and emergency services and up to 30 beds where patients can be observed for a maximum of 48 hours. As opposed to hospitals, patients are not admitted as inpatients at community health centres (Cullinan 2006: 7).

[26] A clinic is defined as a facility at and from which a range of PHC services are provided, but that is normally open only 8 hours a day (Cullinan 2006).

[27]Health Service changes In Gauteng, 26 June 1997 http://www.info.gov.za/index.html

The focus of the research was specifically on public hospitals or clinics as opposed to NGOs and private healthcare providers because of the relative ease with which health care is accessed in the latter. The selection of Hillbrow Community Health Centre reinforces the argument of Atkinson (1992) that the field is not a pre given entity that exists out there. In fact it is an entity conceptualised and constructed in the mind of the researcher through engagement and transactions, in this case with the front line service providers and the hospital management (Atkinson 1992). Through these efforts of thinking through the kind of field that would best represent what the research was looking to investigate and theorise; Hillbrow health centre presented the most ideal option.

4.2.2 Profile of the Patients Who Access Healthcare Services At HCHC

The information gathered from interviews with the frontline healthcare providers shows that the facility attends to patients from a host of African and Asian countries. The following statement by one of the healthcare providers sums up the kind of patients that they deal with at the community health centre:

> Zimbabweans make up the majority of patients visiting the clinic. Other nationalities frequenting the clinic; are Nigerians, Mozambicans, Malawians, Congolese, Senegalese, among others. The majority of the foreign patients coming to the clinic do not have documents, not that it is a requirement but we ask especially when their names are difficult to pronounce or spell. (HCHC Interview 2009/09/30)

Other nationalities include Pakistanis, Bangladeshis, Somalis, and Ethiopians among others. From the observations of this research and information from the frontline healthcare providers it could be

plausible to point out that the majority of the patients coming to the clinic are in the 20 to 30 age set and mainly female. The frontline healthcare providers shared that the young females frequent the clinic to seek termination of pregnancy services. While termination of pregnancy is the service commonly sought by young girls, other disease frequencies are perceived to be seasonal. During winter the commonly reported ailments are flu and fever while summer often sees an upsurge in headaches and diarrhoea. The age of the patients is consistent with the findings of other researches that migrant populations are comprised of the young and productive age groups (Vearey et al. 2009, Landau 2006b).

My observations and perceptions on the characteristics of migrants challenge the perception by the frontline healthcare providers that foreign nationals come to South Africa as health seeking migrants and underline the fact that migration is selective. If the migration patterns have turned substantially towards health seeking, it would have shown in the profile of migrants coming to the centre. The profile would have at least included some people who are recent arrivals and some old people. This is not to say that cases of people coming specifically for healthcare are absent but to indicate that the extent is low compared to those who are already here and fall ill while in South Africa.

The measure of people coming to seek healthcare at HCHC is heightened by those who access ART. In an interview with this researcher, a sister at the HCHC ART clinic stated that there are people who come as far as Zimbabwe to enroll for ART at the clinic and some come on a monthly basis to access their allocation. Since opening its doors in 2004 the ART clinic has a cumulative number of over 7500 clients to date and records about 200 new clients every month. Despite being located in the inner city, the ART

clinic records a significantly low number of migrant clients (30 to 40%)[28]. The staffs attribute the low numbers to the fact that the clinic only opened its doors to migrants fairly recently and until then it dealt with South African nationals only. As a matter of fact, it has been 3 years since the 2006 directive on access to ART by refugees and asylum seekers was put in place. Even with the directive in place, the clinic still has a majority of local clients and the following extract from an interview with a staff member illustrates this point:

> She says "some of the migrant clients fall out of the system because they enrol here in South Africa and then go back to their countries". She singled out the case of Zimbabwe that some clients report some difficulties in enrolling for ART and come and enrol this side and get a transfer letter and continue in their country. Some even come here every month to access ARVs (Field notes 2009/11/19).

4.3 The Structure and Context of Frontline Healthcare Providers' Work

4.3.1 The Hierarchy

The community health centre has different departments that render a wide range of services to patients. The frontline healthcare providers are at the bottom of the power hierarchy and answer to the chief clerk whose duty is to oversee their work and report to facility management. At the time of the

[28] Personal communication with head of the ART clinic in Hillbrow, 2009/11/19

fieldwork there were 8 (4 male and 4 female) frontline healthcare staff at the community health centre. Occasionally the chief clerk and one lady who is a messenger would come and help out at the front desk. However the eight counters at the front desk are seldom fully staffed on any given day due to involvement in other commitments by the frontline healthcare providers. On average there would be four staff members serving clients at the front desk during pressure periods, i.e. in the morning and early afternoon. The frontline healthcare providers have a duty roster that allows each member to be on counter one for a week on average. Counter one deals with the issuing of doctors' letters and is not as busy as the other counters hence the frontline healthcare providers have adopted a rotation system.

4.3.1.1 The Registration Process

Patients come to the health centre as early as 5 am in the morning and wait in the waiting area outside the main entrance to the community health centre. The health centre opens its doors at 8 am and takes patients in groups at different intervals depending on the speed with which the frontline healthcare providers process the clients. The people responsible for letting in patients are the security guards and some queue attendants. The sitting area for patients waiting to go to the front desk consists of about 30 chairs with a couple of them broken and a Television Set (TV) that is not working. Above the frontline healthcare providers' section there is a digital banner showing the date, time and the words:

> Welcome to Hillbrow community centre. Please be patient you'll be attended to in due course. Have a wonderful day

The process of registration involves the frontline healthcare provider greeting the patient (commonly in Zulu) and asking what health service they require. If the patient has been to the health centre before and has a file, the frontline healthcare provider puts a date stamp and tells the patient to join another queue that leads to the consulting rooms. If it is the patient's first time at the community health centre, the frontline staff would ask the name and surname of the patient, marital status, occupation age and the address which he or she writes in the new file (see appendix 3 for the registration form). The frontline healthcare providers fill in the first section of the form (appendix 3) only and leave out the section on the patient's income and number of persons in household because primary health services are free of charge at the health centre. Patients often produce documents without the frontline staff asking, and sometimes the frontline healthcare provider asks for the documents though they are not a requisite for access to primary healthcare. This is the point where decisions are made as the interaction between the frontline healthcare providers and the patients becomes an important factor in determining the decisions that the frontline staff make. As would be argued in the subsequent sections of this paper, outright refusal of access is not common but the sum of the attitude and other non verbal cues that are part of the interaction at this stage could be enough to impact negatively on the degree of fit between migrants and the healthcare system. This research did not record any situations where patients were turned away because of documentation. Patients would be turned back in situations where they admitted to having previously visited the health centre and did not bring their files; in such cases they would be told to go back and bring their file. Common situations of people being turned away related to those seeking termination of pregnancy services; these can only be done by appointment and the doctor comes at specified times of the day. The following extract illustrates this point:

> During that time, the female healthcare provider turns away 5 young women. At first I could see her telling them to go and come back tomorrow morning. On the fifth young woman I gather enough courage to ask why she keeps turning them away. She explains that they have come to terminate pregnancies and the doctor is only here in the morning and attends to a set number of patients before he leaves for another hospital. During my time at the front desk the four staff members, two male and two female appear to be attending to everyone who comes without asking for documents except in cases where the patients present documents by themselves (Fieldnotes, 2009/09/22).

4.3.2 The Career Ceiling: Lack of Opportunities for Advancement

A critical component of street level work is the creation of routines and internalisation of procedure. It emerged from the research that the majority of the front line service providers have been working at the institution for close to 20 years. During the 20 years they have only moved in terms of notches[29] and levels of seniority within the same posts. Front line service appears to have very limited turnover[30] of staff and unless there is an opening at a different clinic there is no promotion beyond the post of senior clerk. The following extract from a conversation with one of the female staff members serves as an illustration of the foregoing.

> She shares that she used to work at Johannesburg hospital (now Charlotte Maxeke) and was transferred to Hillbrow because she was having transport problems and has been working for more than 15 year now. She started at the burns unit. On the issue of the frontliners being in the same job for more than 20 years,

[29] A notch is an allegory of upward mobility within the hierarchy that the clerks attain relative to the length of service and measure of performance at the institution.
[30] relative rate at which an employer gains and loses staff

> she explains the same point given by a colleague that there is a general lack of opportunities for advancement within the health department. Once you reach the level of senior clerk it means you have reached a ceiling beyond which you cannot move further except if there are vacancies arising in other clinics that require chief clerks. Now the system has changed and you remain a senior clerk, you do not become a chief clerk until there is an opening elsewhere. The system that was in place before was such that you could be a chief clerk even before you find a job elsewhere and the salary rises with the level of seniority in the job (interview with clerk at HCHC 2009/10/30).

The lack of career advancement results in the frontline staff struggling to find alternative ways of advancement. The frontline healthcare providers apparently do the same tasks and can only move into management once there is an opening in another clinic. The following extract from the field notes illustrates the frustrating nature of the street level bureaucrats' job:

> She (female healthcare provider) has been working here since 1982 and has been doing the same job. She says there is no challenge and the job does not offer any opportunities for advancement. She says, "Even if I resign and go to other places I will still be doing the same job. Even if I go to another clinic in Zola[31] I will still be doing the same job" She started as a junior clerk and rose through the ranks, and she confirms what the others have been saying that in order to move up you have to move out of Hillbrow and get a job elsewhere.

[31] Zola is a place in Soweto, southwest of Johannesburg

4.3.3 Street Level Frustration: The Frosty Relationship with seniors

From the conversations and interviews with the frontline staff it emerged that there is an uneasy relationship between the staff and their immediate superior. The issues ranged from lack of promotion to backbiting and outright broken communication lines. The following is an extract from a conversation with one of the female staff members which serves as a summation of the relationship between the staff and their immediate superior.

> She continues about the issue of the relationship with management and says: "as people we do not create problems for ourselves and sometimes you get into a situation where you solve one problem and another comes up until the manager says you always have problems" Even if you tell him, he turns a corner and starts presenting a picture that you are troublesome. At work is where we spend most of our time and we must feel that we belong and get moral support but here we do not get that from our senior. There is no good relationship between us and management. I ask her about what is their recourse when they are having problems with their immediate superiors to which she shares that they can go to the top management and says: "Recently there was an informal meeting (informal because we were not taking minutes or anything but discussing our problems) in which we resolved to seek a meeting with the facility manager who came to our meeting. He was not happy because we were having a meeting with the facility manager behind his back and he had not been informed about it. When the manager asked him to respond to the workers complaints he said he had not been informed about the meeting and does not appreciate people going to top management without him knowing. Brenda says she responded to the discomfort of the chief clerk saying when we were suspended you did not even consult with the facility manager but we just saw letters and appeared before people we do not know up there. So it is just the

> same thing with what you did. He felt that I was attacking him and he did not even greet me; we also complained about his tendency to wash dirty linen in public rather than calling you to the office and discussing issues. If you are wrong and someone takes it up in the public you will never admit even when you are wrong, you will just shout back. When I ask her whether that impacts on the performance of the staff she affirms saying: "when you think of coming to work with such a person and you are having problems you would rather stay at home and take your leave days" I ask her the difference between the staffs and the senior clerk to which she says: he does not have qualifications and I am even better because I have managerial skills. He needs management skills this guy and he has been managing for 10 years without results. When I ask how he got the position, she says it was a matter of someone saying 'because I am leaving, I will leave you in charge'. There has not been anyone promoted because of him (Summary of Interview with clerk at HCHC 2009/10/30).

From the preceding extract it is apparent that there is a break in the communication channels between the immediate superior and the frontline service providers. This break breeds frustration in the frontline healthcare providers because they are unable to relate their problems to the chief clerk and even if they do so he (chief clerk) is capable of getting them suspended with the full knowledge that they have problems. The situation is worsened by the fact that he can even bypass facility management and seek suspensions for his subordinates. At the time of the fieldwork, one of the senior clerks had just completed a three month suspension for late coming and absenteeism. This, to the frontline health providers is a show of weakness and lack of interpersonal management skills on the part of the chief clerk. Apparently the chief clerk has been in the position for 10 years and throughout his tenure there has been no one who has moved up the ranks amongst the clerks.

> She says there are no more promotions because the chief clerk is not promoting anyone since he came into the position. 'He found us at the level that we are in and has never promoted anyone'. In terms of the relationship with the management, she appears to be particularly bitter because she thinks that the manager is not doing his job properly, he just cares about getting bad information about the workers. The staffs are not motivated and he does nothing to try and rectify that, he lacks good person to person management skills (conversation with frontline healthcare provider at HCHC 2009/10/30).

While the issue of suspensions could be confirmed with the other frontline healthcare providers it could not be checked with the chief clerk. It is important to note that, while the research is less interested in the dimensions of the conflicts between the frontline healthcare providers and their immediate supervisors, it is necessary to make the point that such conflicts could have a bearing on street level decision making. The circumstances under which the frontline healthcare providers work have the effect of heightening the levels of frustration at the front desk. The high levels of frustration often constitute the baggage that the frontline service providers bring to the front desk and have potential to influence the mood and attitude of the health providers when they interact with patients. This is not to say that frustration alone is enough to impact negatively on the decision making process but to recognise that it is a factor which cannot be ignored and works in combination with other factors.

4.3.4 The Street Level Workload and Client Processing

4.3.4.1 Street Level Work: Overworked and Poorly Paid

The street level healthcare (frontline) providers suggest that the remuneration they get from the department of health is not proportional to the amount of work that they do. The frontline healthcare providers complain that they are overworked at the health centre and speculate that the increasing numbers of migrants coming to the health centre are the reason why they are overworked. The following is an example of how one of the frontline staff makes the point that they are being overworked during a conversation with this researcher.

> She takes the opportunity to say that they (frontline healthcare providers) are being overworked and short staffed because people increase every day. She says 'we are few and do not even fill the counters, there are only 8 of us and serve more than a thousand patients a day' (Field notes 2009/11/24).

The perception by the healthcare providers that they are being overworked and underpaid could have implications for the way they approach the interface with their clients. When such thoughts permeate into their interaction with patients it is likely that the migrant patients who are already prejudiced will often suffer from further discrimination because they are perceived as the cause of the workload. The discrimination is likely to be informed by the fact that the healthcare providers see themselves as serving a population that does not deserve to be serviced. HRW (2009) has documented experiences where migrants are told that certain services are not for foreigners but are meant for South Africans

only. In one of the interviews conducted by HRW, a Zimbabwean migrant complained that when he asked for an x-ray at Hillbrow clinic he was told that the service is for South Africans only. He was told to go back to Zimbabwe if he wanted an x-ray (2009b: 56). The primary health services at the community health centre are provided free of charge to all patients regardless of nationality. This, according to the frontline healthcare providers increases the workload as people are not discouraged by the cost of healthcare services that could be charged in other institutions. While the research by Human Rights Watch focused on a biased group that had been denied access at public health facilities, this research looks at much more than denial of service, it looks at the interaction between healthcare providers and migrant clients. Cases of people facing outright denial of services were not observed during this research and from the observations they seem to be exceptions rather than the norm at the community health centre.

4.3.4.2 Registration Changes and Implications for the Healthcare Providers' Workload

While the frontline healthcare providers could not acknowledge changes, the fieldwork confirmed that the change in the registration system relieved the pressure at the front desk. The initial system meant that the frontline healthcare providers did the registration for the whole facility and attended to all patients, i.e. new entrants and chronic patients. The new system which had been previously used at the health centre allows patients going to specific units within the facility to be registered at those units rather than coming to the front desk. The reintroduction of the old system has resulted in the

employment of additional registry staff to take up positions in the different units of the community health centre. The following extract portrays the results of the change in the registration system:

> I still can't believe why there are so few people today and its only 11:30 in the morning. There are about 15 patients waiting in the queue as opposed to more than 50 that would be here on any other day at this time (Field notes 2009/09/30).

Following the reintroduction of the old system, client numbers dwindled at the front desk. However the frontline healthcare providers believed that the relief was only temporary as the numbers would eventually increase as people become aware of the reintroduction of the old system. The reintroduction of the old system does not imply a reduction of the number of patients coming to the health centre but has implications for the staffs at the entry level of the institution. It means that there is a reduction of the work load at the institutional front desk but the frontline healthcare providers are still not satisfied as they believe that they are being overworked. This is consistent with the argument that the practice of the street level bureaucrat is at times self serving and aimed at looking out for better conditions of service and making the best out of the subsisting work circumstances (Rynbrandt 2005).

4.3.5 Street Level Work: The Division of Labour at the Frontline

The distribution of the work among the frontline healthcare providers is also an important factor that needs to be highlighted. The days at the clinic are not the same; there are pressure days like Monday,

Tuesday and Thursday. This was observed during the fieldwork and influenced the scheduling of interviews and observation by this researcher. The following is an extract from one of the conversations with a frontline healthcare provider in connection with the distribution of pressure through the week.

> On my way out I pass through the front desk where there is one of the female healthcare providers I spoke to on the day I started the fieldwork. We share a few jokes and she tells me that today there was no pressure at all and that the days that have lots of pressure are Monday, Tuesday and Thursday. She tells me that they have since called Thursday; Sheila's day because there are a lot of women who come on that day. She says for some reason women who work as domestic servants are given a day off on Thursdays and they come to the clinic. She says it is the busiest of the week followed by Monday because they are closed during weekends (Field notes 2009/09/30).

The frontline healthcare providers attend to most patients in the morning and this is the period when there is a lot of pressure for the staff. There are often tussles over who takes their tea break early among the staff. Those who take their break early are perceived to be better off because they avoid the high pressure period. When they change shifts, most of the patients would have been processed and it means a greater workload for those that take the later break. While this cannot be directly implicated in the frontline healthcare providers' behaviour at the interface, it portrays the agency and coping mechanisms of the providers in attempts to avoid high pressure times. Besides the tussling over who takes their break first, sometimes there are issues when all the health providers are in the backroom and there is no one at the front desk. The following observation serves to illustrate this point.

> To my surprise there is no one attending to patients…. I go straight to the back where I know I will find the front liners. Indeed I find them, 3 of them; two female 1 male. The male is busy preparing files while the

> other two are chatting and complaining that they are tired. They keep pointing fingers at each other and quarreling over which one of them should go and serve patients. To me this is a fundamental attribution error which might result in none of them going to work. They are also complaining that they are overworked and poorly paid. (Field notes 30/09/2009)

The preceding extract shows some issues that have a bearing on street level decision making and could amount to a lack of access to healthcare by certain groups of patients. It could be observed that sometimes patients would wait for close to 30 minutes without any of the frontline healthcare providers attending to them. The delays in attending to patients have implications for patient responsiveness and attitude in approaching the interface. The point here is that patient could get agitated because of the waiting which could lead to quarrels with the frontline staff which also has implications for the patient's chances of getting good service from the staff.

4.3.6 Street Level Healthcare Providers' Fear of Intrusion

It is worth noting that the staff reacted differently to the presence of this researcher at the community health centre. While difference is characteristic of human agents, some of the reactions could be analysed to reveal the nature of the interaction between the researcher, the healthcare providers and the migrant clients at the community health centre. The reactions ranged from subtle refusals to share information or answer questions to open hostility towards the researcher. The least interested were the

male members of the frontline staff. The following extracts from the field notes illustrate the instances when the researcher had to grapple with difficult potential participants.

> While she is reading one of the female frontline healthcare providers takes note of the silence and thinks maybe nothing is going on and suggests that I go over and speak to one of the male frontline healthcare providers sitted on the opposite desk next to the door leading to the casualty department. The male healthcare provider like the rest does not even want to hear about the research. He is very evasive and says he is busy when to me he is just sitting and there is nothing occupying him and has been sitting there for close to 10 minutes now. One of the female frontline healthcare providers tries to explain to him the nature of the research but he is adamant that he is busy despite the female staff members insisting that I go over and speak to him nonetheless. I intervene and make the point that if he is busy I won't disturb, I will speak to him when he is free. I turn my attention to the female healthcare provider that I had started interviewing; she has finished reading the information sheet but the expression on her face shows that the stuff is very alien to her (Field notes 28/09/2009).

The preceding extract illustrates one of the many instances when the researcher unsuccessfully tried to set up interviews with some of the male frontline healthcare providers. The logical explanation for the male frontline healthcare providers' behaviour could be the lack of trust in the researcher and the fear that the researcher could have been an informer for management. One of the male service providers agreed to speak to the researcher because he thought that the researcher was some official from the department of health. He thought the researcher was at the institution to address the challenges that they face as frontline healthcare providers. On hearing that the research was less about the circumstances of the frontline healthcare providers, the participant could not wait to cut the interview

and reschedule for another day. The following excerpt sums up the interaction with the male frontline healthcare provider:

> We proceed to the front desk where we start our conversation and he appears to have been expecting some form of formal conversation perhaps something more businesslike and maybe centered on their working environment. There is a sense of disappointment in his eyes as the interview begins to unfold and he is quick to postpone our interview to the following day. He says he is knocking off but to me it appears it is just an excuse to duck the interview after I have told him that we are not finished yet (Field notes, 07/10/2009).

From the preceding extract it is plausible to deduce that the conversation diminished in importance as the anticipation of the frontline healthcare provider waned. Upon discovering that there was less to be gained on his part, he began to attach little importance to the research process. The same could be said for the chief clerk who was eager to take part in the research during the initial phases of the fieldwork but grew increasingly hostile and less interested as the research progressed. The hostility in most of the frontline healthcare providers was exhibited in unfriendly faces and avoidance of the researcher as the following extract shows.

> Today I arrived at exactly -13:40 hrs. The frontline healthcare providers are not present and the only logical explanation is that they have gone to lunch. Indeed one member that is seated at the back having a meal confirms that. The male healthcare provider is everything but friendly and for a minute I am intimidated by his demeanour. Maybe he does not trust me or he is plain unfriendly. In our previous encounters he has often worn a face that says “do not come near me.” His attitude and nonverbal cues

> say it all. He is the same frontline healthcare provider who refused to speak to me on one occasion (28th September 2009) and pretended to be very busy (Field notes 2009/10/14).

The occasion described in the preceding extract illustrates the evasiveness of some of the male members of staff. Such instances appear to be attributable to a fear of the unknown on the part of the staff. They were not sure of the purpose of the researcher's presence at the institution and chose to withdraw themselves from settings that could allow conversation. Male frontline staff members showed their discomfort through a display of apparent hostility to the researcher in the form of ignoring greetings or even avoiding spaces that the researcher frequented. The reluctance to speak to this researcher amounted to a fear of intrusion on the part of the male health providers who might have thought of the researcher as an informer for management or some watchdog. While the simple argument of this research has been that the healthcare providers could have feared the intrusion of the researcher in their personal work space, on closer analysis of the frontline healthcare providers' behaviour it is plausible to posit that there could have been certain behaviours that they wanted to hide. This latter argument is informed by the reaction of one service provider when a patient came to seek healthcare at the institution around 3pm.

> There is a patient who comes to seek help, apparently he was involved in an accident and she says, "These people come at their own time and we must be nice" (Field notes 2009/10/14).

The statement reveals a reluctance to serve clients who come to the community health centre late. The statement gives the impression that the presence of the researcher could have played a role in the

guarded interaction of the healthcare provider and the patient as the statement is directed to the researcher, not the patient. The way the words are said reveals the possibility that ordinarily the patient could have been ill treated. Such statements are also strategically directed at the researcher as evidence that clients present a multitude of problems at the interface and therefore certain behaviours in reaction to client characteristics are acceptable. The point here is that the frontline healthcare providers would often try to be convincing to the researcher and in the process justify their actions by shifting the blame to the clients rather than assessing their own role in the interaction. In fact it is more about being correct and the migrants being in the wrong all the time. This is the image that the healthcare providers often tried to portray to the researcher especially after discovering that the researcher is a foreign national. The attempt to convince the researcher that there is nothing sinister happening at the interface was also a characteristic of the interaction between the researcher and migrant clients. The healthcare providers always portrayed some normalcy of sorts at the interface and the explanation of problems would be phrased to implicate migrants. Migrants would also point fingers at the healthcare providers for any conflicts that would happen at the interface.

The frontline healthcare providers who spoke to the researcher did not only project themselves in a good light but also tried some subtle ways of getting through to the researcher and assessing his motives. It is interesting to note that throughout the research the frontline healthcare providers remained unsure about the purpose of the motives of the researcher at the community health centre. The mistrust was apparent even in plain conversations like the one described below.

> While chatting at the back, a certain staff member comes and makes a joke about hitting a patient in a way that is loaded and aimed at getting a response from me. I just respond in an innocent way and say,

> "why did you beat him?" I am looking at generating a conversation around this beating incident but I am interrupted by one of the ladies. I am extremely annoyed though I am trying hard to conceal it when she tells the male staff member that he is talking to the wrong person and the male staff member leaves (Field notes 07/10/2009).

In this exchange, the male staff member is looking at getting a response from the researcher to gauge his loyalties and reaction to the joke. The female health provider provides that answer and the male member leaves without continuing with the conversation. Conversations like these illustrate the pensive nature of the interaction between the health providers and the researcher. Even when the health providers knew about the purpose of the research they still felt an urge to be thoughtful in their responses and be on guard just in case they could let out some information that they felt could be detrimental to their jobs. While the perceptions and reactions of the service providers in interacting with the researcher cannot be summed up as important determinants of decisions made at the interface, they reveal some influence on the realities at the community health centre and the data collected.

4.4 Factors Influencing Health Providers' Decisions

4.4.1 Street Level Discretion and the Relationship between Healthcare Providers and Migrants

Despite the frontline healthcare providers professional outlook to their relationship with migrants there is a tendency to think that migrants do not deserve the healthcare. This is shown in the healthcare providers' sentiments to the effect that migrants owe the health access to the frontline staff. The frontline healthcare providers sometimes think that migrant patients get treatment because of the staffs' own generosity rather than the migrants' rights and entitlements to that healthcare. This could be illustrated by a statement by one of the frontline healthcare providers that,

> If we were cruel we would be sending them away and getting them arrested as well (Field notes, 2009/09/28)

The preceding statement was made by a frontline healthcare provider following a discussion on the challenges that they face when dealing with migrant patients. While the statement was made in reference to the use of fraudulent documents by the migrant patients it underlines the discretion that the healthcare providers have over the decisions that they make at the point of intersection with migrants. The kind of discretion that is exercised by the front line healthcare providers at the interface could be understood as being both a necessity and a liability (Evans 2009). According to Lipsky (1980) discretion is inevitable and forms a significant part of street level decision making in the provision of public services. In analysing the use of discretion, Peters and Pierre contend that, "delivering social

services in an efficient and effective manner presupposes that the services are adapted to individual needs" (2000: 17). Therefore, the services have to be responsive to client needs and discretion at best ought to be exercised in the service of the client. The clients often have different needs that cannot be served by a strictly routinised decision making process and discretion is necessary to allow a degree of fit between the clients and the healthcare system (Peters and Pierre 2000). While discretion is positive in attuning services to the clients, wide ranging discretion is less desirable because of instances of arbitrariness in the decision making process that are common at the point of intersection between the frontline healthcare providers and migrants. An excerpt from the field notes captured on a different day also serves as a valuable illustration of the authoritative attitude of the frontline staff.

> The male frontline healthcare provider to my left from his facial expression I can tell that he is not at ease with my presence at the front desk and bursts into spurts of tough talking when addressing patients. He seems to be controlled because of my presence perhaps he is not sure what I am doing here and the whole objective of my research. I can hear him shout at the patients saying, "You are lucky that you will be treated so stop complaining." He makes it seem as if the woman is there because of his own generosity rather than the need for treatment and her right to claim the healthcare she is entitled to (Field notes, 2009/09/23).

The frontline healthcare providers particularly obfuscate their roles primarily as disbursing services and engage in judging the suitability of certain clients to get medical attention. In doing so the healthcare providers usurp the powers of the state in deciding who gets healthcare and in what quantities and quality. The point is that, it is the state that has the responsibility of formulating policies to govern the work of the street level bureaucrats and as such, the state decides who should access treatment at the

public facilities, not the frontline healthcare providers. It is important to clarify that in making this argument, the research does not seek to undermine the agency of the street level bureaucrats and their role in constituting what eventually becomes public policy. Maynard-Moody and Musheno (2000) describe the street level bureaucrat as occupying an intercalary position and balancing their simultaneous role as state and citizen agents (see section 2.2.3 in this paper). As argued elsewhere in this paper, the street level bureaucrats have the power to act on behalf of the state as occupiers of the nether rungs of the state power. They also have the capacity to act on behalf of their clients as the employees closest to the public that the state services. The point here is that the street level bureaucrats have the propensity to develop rule bending mechanisms in the service of their clients. When the street level bureaucrats internalise and follow the rules, they act on behalf of the state and when they bend the rules in favour of the clients they act on behalf of the clients. It is important to make the point that the street level bureaucrats do not only act in the service of clients alone but also act in the interests of their own well being and the creation of conditions that are favourable for their work (Moore 1990). The frontline healthcare providers have been observed to act on behalf of the clients when they fail to make police reports about migrants who produce fraudulent South African IDs at the health centre.

> She relates a story about a certain migrant woman who came to the clinic with an identity document bearing a photo that is young enough to be that of her daughter. The old woman was allegedly adamant that the ID belonged to her though it was quite obvious to everyone present that it was not hers. She continues, saying that the ID was a newly acquired one and on being quizzed the old woman admitted that she bought the document (Interview with clerk at HCHC, 2009/10/19).

The preceding extract illustrates one occasion described by one of the healthcare providers in which a migrant patient produced a suspicious identity document at the front desk. The frontline healthcare providers in this instance were supposed to alert the police but they chose not to. While this behaviour can be understood in terms of Maynard- Moody and Musheno's (2000) citizen agent narrative it could also be seen as self serving on the part of the frontline healthcare providers. The point here is that the common reason that the healthcare providers give for not reporting such cases to the police is that they would not want to spend a lot of time in the courts as witnesses. In what Peters and Pierre call 'coalitions between clients and bureaucrats' (2000: 18) the healthcare providers have been observed to go out of their way to contravene organisational protocol in the service of certain clients[32].

4.4.2 The Power Relations and Symbolic Violence by the Healthcare Providers

Apart from having a sizeable amount of discretion at the interface it is also worth noting that the frontline healthcare providers occupy a more powerful position in their interaction with migrants. As noted in the preceding section, frontline healthcare providers sometimes shout at the patients in terms that remind the patients that access to healthcare depends on the staff. There is often arbitrariness on the part of some of the health providers when they deal with migrants and the attitude is often encouraged by the migrants' timidity when approaching the front desk. Interviews with migrants yielded information on the treatment they get in their interaction with other healthcare providers beyond the front desk. While the information pertains to migrants' experiences beyond the research's unit of

[32] See section on categories in the next chapter (5)

analysis (frontline healthcare providers) it is valuable insofar as it contributes to the sum total of the factors that could impact on the degree of fit between clients and the health system. The information also sheds light and absolves the frontline healthcare providers of certain accusations that are labelled against the public healthcare system in general and Hillbrow community health centre in particular. There is need to understand the health facility as a "health bureaucracy" in its own right (Anderson 2004: 2003) and as such it is not homogenous but consists of various departments that have distinct and combined effects on the degree of fit between the health system and the healthcare needs of migrants. The point here is that there are factors that affect migrants' access to healthcare that do not result from the migrants' interaction with the frontline healthcare providers but are the result of interaction with other healthcare providers in the health facility. Frontline healthcare providers form a section of the bureaucracy and their role is limited to the admittance of patients into the facility and the other functions are performed by other elements within the institution. This means that they do not control what happens beyond the front desk and underlines the heterogeneity of the bureaucracy itself and the need for further studies that cover the institution in its entirety.

In the focus group discussion with migrants at the central Methodist church it emerged that there are cases where women accessing reproductive healthcare at the community health are treated badly. The treatment appears to be grounded less on lack of knowledge for existing legislation but deliberate bad behaviour on the part of the healthcare providers. The following extract from the CMC FGD portrays one of the instances detailed by a migrant woman.

> CMC4: When I got there, they were complaining about the fact that I had been assisted at the MSF. They spoke in Zulu and thought I couldn't hear. They were talking about an incident that had happened the

previous day involving a man from Zimbabwe who had threatened to get the nurses arrested for ill treating his wife.

K: Did that influence the way they treated you?

CMC4: I think that is what they always do to Zimbabweans because they always complain when handling foreigners

CMC1: When I was at the hospital there was a lady from Nigeria who had been there for three days and the nurses were saying she should go and give birth in Nigeria. They were busy complaining while the lady was in pain.

CMC2: If they hear that your husband has come to see you they begin to speak to you well. They change the way they speak to you.

K: Why?

CMC2: They fear that the husband might go and report to management and get them into trouble. When he is gone they start again

The exchange here reiterates the point that the health providers for the most part are aware of what they do and have full knowledge of the consequences of their behaviour. In terms of the migrant women interviewed, if the healthcare providers know that the patient has no recourse whatsoever they subject them to all sorts of humiliating treatment. This illustrates how the healthcare providers draw from their own resources (perceptions) in dealing with migrant patients. The point here is that, the health providers are subject to disciplinary action by institutional management and they particularly target what they consider to be soft targets for their anti foreign sentiment. The inclusion of this section

serves as an illustration that there are certain instances that impact on migrant access to healthcare that are least understood in terms of the primal[33] definition of access into the healthcare system. Entry into the healthcare system denotes the registration which is done by the frontline healthcare providers but full access includes the freedom to unhindered utilisation of services by the migrant patient. As argued elsewhere in this paper, the perspectives of the healthcare providers (nurses and doctors) in the reproductive health section were not captured and by implication the views represented here are those of the migrant patients.

The healthcare providers also do not take kindly to being reported or confronted about their behaviours as shown in the preceding excerpt. The case of the Zimbabwean man who had threatened the nurses with legal action the previous day is particularly interesting. It reveals the displacement of aggression by the nurses towards some vulnerable groups and in this case patients from Zimbabwe have to pay for the perceived misdemeanours of a previous client. The foregoing illustrates the potential that events of the previous day have in determining how clients who are considered to have similar dispositions could be treated. As shown in the preceding excerpt, the nurses could not stop talking about what had transpired the previous day in the full hearing of the other patients. In this regard the events of the previous day are not only used in discriminatory statements but as a deterrent to further action by those subjected to unkind attitudes and abuse at the hands of the healthcare providers. This is akin to the analogy of symbolic violence[34] described by Bourdieu (1989) when he argues that sometimes people in positions of authority engage in concealed threats of violence to scare those in the lower end of the authority

[33] Here, I refer to the use of the definition that access to healthcare is simply entering the hospital
[34] Symbolic violence describes the tacit and unconscious modes of cultural/social domination occurring within the every-day social habits maintained over conscious subjects (Parkin and Coomber 2009)

spectrum. The violence in such cases is not explicit but implied in the actions of the service providers. The use of nonverbal and verbal cues by the healthcare providers is important and underlines the unequal relationship between the staff and migrant patients at the interface. It is useful to clarify that, the healthcare providers do not interpret their behaviour as violence but understand it is a natural reaction. A case in point is the look and facial expression given to the troublesome[35] patient which results in the patient keeping quiet. In such instances the actions of the frontline healthcare providers are tacitly violent rather than explicitly so (Bourdieu 1989).

While symbolic violence is the common form of deterrent behaviour at the front desk, there are instances of physical and verbal assault involving healthcare providers and patients. The following extract illustrates one such case:

> While still chatting with other staff members; we hear some noise from the direction of the front desk. The female healthcare providers are quick to rush to the place where the noise is coming from. After waiting for a while I follow them and try to understand what is happening. I am greeted by the sight of a young man, in the late teens with blood in his mouth and brandishing two empty liquor bottles. Apparently he is a patient at the clinic and has been assaulted by one of the staff members at the clinic. I try harder to get the whole story but my efforts are not that successful as I get bits and pieces, nothing coherent. One old woman[36] comes up and shouts at the patient accusing him of coming late and causing problems. She tells everyone that the boy was here yesterday and she is surprised to see him again today and turning to the young man, she asks; 'why are you here? Weren't you treated yesterday?' The young

[35] For a detailed discussion on the troublesome patients and other patient categories see chapter 5 in this paper
[36] This woman works at the Hillbrow Community Health Centre but is not a clerk

> man is quiet all this time and looks shocked; perhaps he wasn't expecting what has just happened to him (Field notes, HCHC 2009/10/07).

Though the healthcare provider who verbally and physically assaulted a patient was not one of the front line healthcare providers, the preceding extract portrays the weakness in the position of the migrant in his or her interaction with the healthcare providers at the community health centre. It is important to also note that the incident described here does not happen spontaneously but is rooted in the activities and nature of interaction preceding it. The patient involved in this case has been to the community health centre before and has been understood as a troublesome patient by other healthcare providers. The researcher could not get the full story because the patient involved seemed reluctant to engage in any conversation.

The frontline healthcare providers' opinions are divided on the issue of assaulting patients at the community health centre. Most of them condemn the practice of hitting patients as unacceptable no matter what the circumstances are. Suggestions are that the healthcare provider who assaulted the patient must go for lessons on how to handle situations where he is involved in an altercation with a patient. Some of the providers however take the side of the staff member and argue that perhaps the patient insulted him and he could not take it anymore. One of the staff members gives an example of a similar situation with a patient who insulted her, she says:

> I just kept quiet and didn't respond until it was his turn to be attended at the front desk. I asked him why he is insulting me, what have I done to him. The guy couldn't stop apologising for his actions simply because I had kept my cool and not reacted angrily. (Field notes HCHC 2009/10/07)

The preceding extract portrays the frontline healthcare provider as a professional with the ability to withstand insults and deal with problematic patients amicably. It is important to also note that patients present problems at the point of intersection as shown in the foregoing discussion where the patient was holding beer bottles and looked visibly intoxicated. In such cases there is bound to be problems at the interface though the least desirable effect is the deterrent behaviour that the healthcare providers employ in subsequent interactions with patients.

4.4.3 Knowledge of NDOH and GDOH Policy Directives

The decisions that the frontline healthcare providers make at the front desk could be best summarised as inconsistent. In dealing with migrant clients (both documented and undocumented) the street level bureaucrats to a large extent do not deal with them on a case by case basis. The point here is that the frontline healthcare providers have adopted ways that allow for bulk processing[37] of patients in order to circumvent the workload. The decisions made conform to the regulations laid down by the management of the institution regarding the critical day to day conduct of both the bureaucrats in particular and the institution in general. The basis for this argument is the observation that the frontline service providers seem not to be aware of the different pieces of legislation governing the treatment of the different categories of patients (both migrant and citizen). In fact the front line service providers do not see

[37] In terms of this paper, bulk processing refers to a situation where the front line service providers device uniform ways to deal with clients to speed up the process of service delivery and reduce the excruciating nature of their work load.

themselves as implementing policy but just following procedure as instructed by management. When asked about the reference point for their decisions they often allude to an announcement by the institutional management regarding the course of action or the change thereof. There is no mention of the NDOH and GDOH directives regarding the treatment of refugees and asylum seekers in their responses. As a result, the distinction between documented and undocumented is less important in the provision of healthcare at the community health centre. The point is that the healthcare providers do not rely entirely on the presentation of documents to make decisions regarding the registration and provision of healthcare to the migrant clients. The frontline healthcare providers' lack of comprehensive information regarding the different directives by the NDOH and the GDOH has allowed for the opening up of access to all categories of migrants. In the words of the frontline healthcare providers, 'documents are not a requirement at the health centre' every patient is treated regardless of whether they have documents or not.

It is important to recognise that the NDOH and GDOH directives do not make specific reference to the undocumented migrants who are neither refugees nor asylum seekers. In the preliminary arguments and justification for this research the category of undocumented migrants assumed some importance in exploring the role of the front level bureaucrats at the community health centre. As the research developed, the specific category of undocumented migrants collapsed into the more general category of cross border migrants because of the apparent lack of document based selectivity in the allocation of healthcare at the health centre. The instruction from facility level management was that the healthcare providers should attend to every patient regardless of whether they have documents or not.

Contrary to the belief by some refugee service providers (Refugee Nurses Association)[38], the frontline healthcare providers at the community health centre have knowledge of the different documents that migrants use. It is important to clarify this point in order to substantiate the argument that the discrimination that often takes place at the community health centre is not entirely based on documentation. Making a contribution during a focus group discussion a member of the Refugee Nurses Association (RNA) noted that some healthcare providers in the public health sector are ignorant of the existing legislation and refugees' documentation. In terms of the RNA, some healthcare providers in the public sector:

> Do not know the section 22 asylum seeker permit.... they just ask for a South African identity document (FGD with MHF members, November 2009)

While instances where the healthcare providers display a lack of knowledge about the existence of an asylum seeker permit cannot be discounted, none were observed in this study. Refugees and asylum seekers have been in South Africa for a long time, long enough for the healthcare providers to know the different documents that they use. This could not be a lack of knowledge on the part of the healthcare providers as the RNA puts it but could be just an inconsistence in dealing with migrant patients coming to the public health institutions.

[38]Refugee nurses association is a recently formed organisation that consists of refugees and asylum seekers who have professional nursing qualifications. The mandate of the RNA is to lobby for the registration of its members with the South African Nursing Council and represent the grievances of qualified refugee nurses to the NDOH.

4.5 The Voices of Migrants at the Interface

The fieldwork generated information on the different experiences by different categories of migrants at the hands of the healthcare providers. The descriptions of migrant experiences involve interaction beyond the front desk and include experiences with the nurses and doctors. The inclusion of these experiences does not deflate the focus on the frontline healthcare providers but widens the scope of the research to better understand the real issues at the community health centre. The overlap is also consistent with the aim of the research not to limit the observations and data gathering to the front desk only but to extend it to any instances that could have a bearing on the migrants' accessing healthcare at the institution. It is important to clarify that the inclusion of migrants' experiences beyond the front desk does not imply a full understanding of the happenings at the level beyond the frontline. The point here is that, the voices of the nurses are absent from this research and as such the research is not conclusive on data that refers to the nurses' conduct in dealing with migrant patients.

Migrants who have sought healthcare at the community health centre report different experiences. There are migrant patients who compliment the healthcare providers and describe their experiences as good and not different from those of the South African nationals. Others however report experiences that range from verbal to physical abuse by the staffs. The following excerpts from the interviews with migrant patients illustrate the contrasting experiences of migrants who have been to the HCHC for healthcare.

> "Chiripo (what is there), I went to Hillbrow; the service for Zimbabweans and South Africans are the same. I went there to book for maternity, what they need is proof of residence and identity documentation from a South African and Zimbabwean alike. It is something they require from everyone." (CMC 5, November 2009)

> "It is not the same because if you speak their language.... (Zulu), you are not subjected to the same kind of treatment as some of us who cannot speak the language with them. If you speak Zulu you are treated much better because the nurses even wrap your newborn baby for you while you rest on the bed." (CMC 3, November 2009)

The preceding quotes describe encounters of two different migrant patients with the healthcare providers at the same institution and underline the inconsistencies of the healthcare providers in dealing with migrant patients. The first had a good experience and could only say positive things about both the frontline staff and the nurses who attended to her while the second had a bad experience. It is important to make the point that most of the bad experiences refer to the interaction between migrants and the nurses rather than the frontline healthcare providers. The foreign migrants interviewed in this research reported bad experiences with the nurses in the maternity ward and the migrant woman in the first quote was the only one who reported being treated well. In the second case, language emerges as an instrument of discrimination used by the healthcare providers to distinguish between nationals and non nationals. The treatment you get depends on the language you speak and the likelihood of getting quality healthcare is related to where you come from. If you are a migrant you can only get better treatment if you speak Zulu and if you cannot converse in the language of the health providers you are

subjected to discrimination and profanity. On her experience with the health providers in the maternity ward, one participant had this to say:

> "Yes it was a case of me not speaking their language and the fact that I am a Zimbabwean. I could hear them saying Zimbabweans are a problem they come and give birth in our hospitals. They even asked me, when I would be going back to Zimbabwe?" (CMC 4, November 2009)

There is an evident dislike and an anti foreign sentiment in the preceding quote which describes the experience of a Zimbabwean migrant giving birth at the Hillbrow community health centre. Similar migrant experiences in the public health sector have been documented by Landau (2006). Landau recounts the experience of a refugee at an unnamed public health facility in the following quote;

> While waiting, one refugee overheard nurses talking about 'foreigners taking government money and having too many babies,' and another reports a hospital staff member describing the hospital as 'infested' with foreigners (Landau 2006:10)

There is an assumption of responsibility by the healthcare providers for protecting government resources and preserving them for the local population that is apparent in the preceding discussion. The street level bureaucrat in this instance assumes the role of government and lives to his or her billing as the face of the state in interaction with the ordinary folk on the street. What is worrying is that there is xenophobic sentiment in the way the healthcare providers are said to have spoken to migrants, an attitude that has far ranging consequences for the foreigners accessing healthcare at the institution. While the frontline healthcare providers are adamant that no one is denied treatment at the health

centre it is highly probable that the sum of the nurses' actions and attitude alone is enough to dissuade 'would be' patients from even setting foot at the institution. In this regard, refusal of treatment assumes a different dimension that is implicit and little thought of by both the street level bureaucrats and the higher level policy makers. A departure from the conceptualization of access to healthcare simply as entry into the system best captures the idea that the failure of the health system to present favourable conditions to the users of the system amounts to refusal of access. The following extract from an interview with a Cameroonian migrant gives an example of the foregoing:

K: Have you ever been to Hillbrow to access treatment?

R: Yes, I have been there

K: How were you treated?

R: I will never go there again the nurses at HCHC are so rude, sometimes you wonder whether there is something that they smoke before coming to work.

K: Why were they rude to you?

R: You cannot understand those people, they are full of xenophobia and they are sometimes also rude to South Africans. The situation gets worse when you are a foreigner and cannot speak Zulu. If you make any mistake they will give you hell and tell you to go back to your country, HCHC is for South Africans. They will ask you why you come and give birth in South African hospitals and not go back to your country.

K: what health service did you seek in HCHC?

R: I went there when I was pregnant but I had to give birth in Coronation because the nurses in Hillbrow are too xenophobic and antiforeigner.

It is interesting to note that some South Africans are also subjected to ill treatment by the healthcare providers. Research in other institutions has shown similar attitudes towards South Africans especially in the maternal health services (Schneider, McIntyre, Birch and Eyles 2006, and Jewkes, Abrahams and Mvo 1998). Schneider et al (2006) citing the argument of Jewkes et al (1998) note that when accessing maternal health services women from particular ethnic or racial groups in South Africa are treated especially poorly by health care workers. But as implied in the preceding extract and argued in other sections of this paper, the treatment is better for South Africans and becomes worse with the degree of foreignness. The point here is that there are foreigners who speak Zulu and in terms of this analogy could be classified in the same category as citizens who belong to ethnic minorities. Foreigners that do not speak Zulu appear to be at the extreme end of the continuum and subjected to the worst forms of discrimination. Those that speak Zulu are treated much better and the ethnic Zulus receive the best treatment.

Both the migrants and staff from MSF confirm that the problem of bad experiences appear to be with the nurses rather than the front line service providers. As noted earlier, it is beyond the limits of this paper to draw conclusions about the behaviour of the nurses because the voices represented in this research are those of the front line service providers and migrants. The following excerpt from an interview with an MSF staff member illustrates the point that the nursing staffs are more discriminatory in their interaction with migrant patients.

K: The problems that result in someone being turned away; are they with the frontline staffs or with the nurses?

R: It's mainly with the nurses

K: Nurses?

R: Yeah, it's mainly with the nurses; they are the ones who are mostly rude and abuse patients verbally: 'saying like, go back to Zimbabwe' and judging patients on their sexual life

K: Ok

R: There is one example where the guy had an STI and was insulted by a nurse to the extent that he wanted to go to a traditional healer to seek treatment

K: Are the patients treated like this because they do not have documents or it is because they are simply foreign?

R: I didn't really register, only in this case that the lady was refused termination of pregnancy because of that. They need documents because they need the signature of the next of kin especially when it comes to issues that may involve blood transfusion (MSF interview, November 2009)[39]

The inconsistencies of the staff in dealing with migrants reinforce the argument by Maynard-Moody and Musheno (2000) that the work of the street level bureaucrats and the judgements they make represent the best and worst effects of institutional culture. The decisions of street level bureaucrats are guided less by rules and procedures but draw more on beliefs and norms about what is fair and in the interests of the institution and the citizenry at large (ibid: 333). Norms and beliefs to Maynard-Moody and

[39] K – Khangelani (researcher) R - Respondent

Musheno are elusive and difficult to change compared to rules and procedures because they are sometimes inconsistent and not well articulated. Perhaps this explains the inconsistencies of the behaviours shown by the health providers in dealing with migrant patients. Rules and procedures aside, the street level bureaucrats often do what they think is appropriate at a given time period and the beliefs and prevailing circumstances at that given time have a bearing on the decisions that they make (Maynard-Moody and Musheno 2000; Riccucci 2005). In understanding the modern state, Maynard-Moody and Musheno argue that it is essential to take account of street level bureaucrats' beliefs as they constitute an important avenue through which the modern state can be explained. While this is not a discussion of the state and it's relation with citizens, it is important to note that the street level bureaucrats occupy the space between the state and the ordinary folk on the streets. They are in the lowest rungs of government and further from the centres of power while at the same time they are the closest faces of government to the public. Being closest to the public they are prone to obfuscating their roles and usurping the power of the state as argued earlier in this chapter. Occupying the space between the state and the public does not necessarily imply that the street level bureaucrats act in the best interests of either the state or the public. In many respects their attitude and approach to work is self serving (motivated by self interests) and paraded through the banner of xenophobia primarily because the institution services foreign migrant communities.

4.6 False Addresses and Migrants' Agency At The Point Of Intersection

It is common for migrants (especially the undocumented) to give false addresses at the front desk. The main reasoning behind giving false addresses is explained in terms of the desire to remain invisible and the perceived threat of deportation on the part of the undocumented migrants. The following extract from the field notes illustrates the reluctance of one migrant to give her physical address at the front desk:

> The conversation gets interesting when it comes to the address; she says she doesn't know her address. Funny enough when the healthcare provider asks her the number and the name of the building and street she responds knowingly (Field notes, 07/10/2009).

The interviews with some of the undocumented migrants showed that there is a simmering mistrust of the health officials and a fear that they can report them to the police. This fear is unfounded as there is no such precedence in the South African context but continues to subsist in the minds of some undocumented migrants to the extent that they would sometimes not go to the public clinics. On the use of fake documents; the conclusion that could be drawn is that there is a general lack of proper information dissemination with some people still hung over policies of yester years. They believe that they will be denied access unless they produce a South African identity book and some do not even access treatment because they do not have documents.

As argued in earlier sections of this paper, a complete understanding of the interface includes the analysis of the behaviour of both the healthcare providers and the migrants. Migrants react in different ways to the way they are treated at the front desk, including the boycott of services and use of fraudulent documents. In making this argument it is important to clarify that the reactions by migrants are not entirely because of the decisions at the front desk alone but also result from lack of information

regarding access to healthcare at public facilities. It is not uncommon to see migrant patients smiling and looking timid when approaching the interface. The following observation illustrates this point:

> Meanwhile I am frontline staff member to the patients who can't even notice that I do not look like one and I am too young in comparison with the real front liners. One of the male patients in the queue keeps smiling and waving at me each time I look in his direction. I do not know why he is doing it and for a moment I think maybe he knows me from somewhere but I can't really remember where I could have met him (Field notes 2009/11/12).

The case portrayed in the preceding extract illustrates one of the many cases observed at the community health centre where some patients would often smile at the frontline healthcare providers and try to establish some rapport of sorts before their turn to be served. This point adds to the above discussion on the agency of the migrants and how they conduct themselves at the interface.

4.7 Conclusion

The interface between frontline healthcare providers and migrants provides a window through which the concept of street level bureaucracy is explored. The decisions that the healthcare providers make involve a sizable amount of discretion and underline the influence that they have on the way that policies and directives are implemented at the point of intersection. The decision making process involves the interplay between the agencies of the frontline healthcare providers and the migrants and this, to a large extent constitutes everyday practice at the community health centre. The interaction is

mediated by the structure and environment in which the street level bureaucrats operate as well as the circumstances that bear on migrant behavior such as language and events prior to arrival at the point of intersection. While the research has focused on the frontline service providers it has also yielded information on events that happen beyond the front desk. This information has been instrumental in reaching certain conclusions on factors that impact on the degree of fit between the healthcare system and migrant patients. The power of the frontline healthcare providers in making decisions that impact on the ability and freedom to freely access and utilise public health services has been observed to be consistent with the state – agent narrative of street level bureaucracy. This makes the point that while elements within the identity of the migrants could be important the decision making often comes down to what the healthcare providers deem fit at a given point in time. The following chapter continues the discussion on the degree of fit between clients and the health system through an exploration of the patient categories used at the interface and the complexities of the language question.

Chapter 5: Patient Categories and the Language Question

5.1 Introduction

This chapter follows up on the preceding chapter and expands the presentation of the reality at the point of intersection between frontline healthcare providers and migrants. The focus is on the creation of patient categories that are imbued with varying attributes and strengthen the case for differential treatment of patients at the community health centre. The section on the creation of categories is followed by a discussion on the effect that the different categories have on the ability and propensity of migrants to freely access healthcare at the clinic. The discussion also touches on the impact of stereotyping on the discourse of membership and belonging. The last section of the chapter focuses on the complexities and furthers the discussion on the multidimensional nature of the language question. This involves a discussion of the impact that language based discrimination has on the decisions made at the interface as well as the coping mechanisms of the frontline healthcare providers.

5.2 Patient Categories at the Street Level

Outside of the institutional legislation, client characteristics and those of the frontline healthcare providers have been observed to play a pivotal role in the distribution of public healthcare services and

sanctions at Hillbrow Community Health Centre. This is most apparent in the way frontline healthcare providers relate to their clients and practically construct them into varying categories with different privileges and sanctions. Privileges in this instance refer to favourable treatment while sanctions describe the bad treatment that some patients face at the health centre. The most salient category is that of the 'Zimbabwean patient' primarily because of the perceived numerical overflow that the northern neighbours have over all the other nationalities accessing healthcare at the institution. This has resulted in the stereotyping of the patients and the perceived health burden that comes with great numbers of non nationals. In the circumstances that healthcare providers work, a burden from the citizen client is tolerable but when the burden is foreign then there must be something fundamentally wrong with the non national patient. This wrong element is what the frontline healthcare providers can pin an outlet to their stresses and frustrations of a perceived strenuous workload. This section details the principles of categorisation and the different categories that the research observed at the institution. This is not to say that the categories are natural formulations of the health providers but acknowledge that they only exist in form but are not concretely named as such by the providers themselves. In essence, the categories were given names by the researcher owing to observation and the different ways in which patients from different countries and backgrounds are treated at the institution. These categories are therefore not imagined but real and derive from what goes on, on a day to day basis at the front line. The categories presented here are; the uninformed patient, the connected patient, the foreign patient, the citizen patient and the Zimbabwean patient.

5.2.1 Uninformed Patient

The uninformed or ignorant patient experiences a measure of discrimination at the HCHC based on the failure to look inward and safeguard his/her own health. According to the frontline healthcare providers this kind of patient typically opens multiple files at the clinic to the point that the frontline healthcare providers can recognise him/her. Instances of healthcare providers recognising patients who open multiple files were not observed during the fieldwork but the frontline healthcare providers shared that:

> It is common for patients to come here without a file each time they come to access services and ask for new files. We even know some of them though there is nothing that you can do; you just have to open the file for them. When we ask them about the file opened in their previous visit they will tell you that they were mugged or the files were lost while relocating to another building, but the funny thing is that the file is the only thing that gets lost. Allegedly the facility spends approximately R100 million on files every month, a horrendous statistic attributed to the flood of Zimbabwean nationals in the health system. (Field notes 2009/10/16)

The preceding extract gives details of an informal discussion with one of the frontline healthcare providers' and shows a perception among the staff that patients deliberately lose files and question the reasons given for the loss of the files. Frontline healthcare providers interpret the behaviour of patients who lose files in terms of ignorance on the part of the patient because it is detrimental to the patient's health. The following extract from an interview with one of the frontline healthcare providers illustrates this point:

> We sometimes turn away a person because of the lying which causes some serious altercations especially when someone gives a different address each time they visit the clinic. Sometimes a person is turned back to go and collect their file because they often want to open new files each time they visit the clinic. The usual explanation is that the file has been lost and attempts at explaining the dangers of constantly changing files are not listened to by the migrant patients (Interview with clerk at HCHC, 2009/09/28).

Another reading of this could suggest a consistency with the desire to remain invisible (see section on the Zimbabwean patient) albeit at the expense of one's health. Information unless made verbally accessible to the uninformed patient, remains a hard to reach commodity. The difficulties that some patients face in the interaction with healthcare providers are avoidable with sufficient dissemination of information to the patients. According to Mladovsky (2006) information in contemporary societies is an important immaterial commodity whose value surpasses that of material goods. The lack of information provision to migrants concerning their wellbeing and what is appropriate could result in their continued marginalisation and subjection to discrimination. The lack of information has been observed to impact on the utilisation of services by some migrants who are not well informed about the changes in the policies and legislation governing access to healthcare in the primary health sector. There is an entrenched belief among some migrants that access to healthcare can only be available if they have a copy of a South African ID.

5.2.2 Difficult/Troublesome Patient

In as much as the front desk is the place where the frontline healthcare providers and patients intersect it is also a place of conflict. There are patients who are seen as causing problems at the front desk and are least liked by the frontline healthcare providers. It is common for such patients to be labelled as foreign and lacking respect for South African institutions and acceptable procedure. Describing a patient, one of the healthcare providers had this to say:

> "I personally attended to the boy who has been assaulted and he is a trouble maker who does not want to stand in the queue. He came earlier and was busy picking fights with other patients in the queue until one of the ladies in the queue managed to calm him down. If this boy had stood in the queue like all the other patients he could have gone home a long time ago but he is just a trouble causer and drunkard" (Field notes: 2009/10/07).

While descriptions represented by the preceding quote are true of experiences at the front desk what follows these kinds of experiences is often least desirable. This description was captured following an incident in which a patient had been assaulted by one of the male frontline healthcare providers at the health centre. The patient left the health centre without getting treatment, and with an injury that could require further treatment in addition to the ailment that had brought him to the community health centre in the first place. It is important to clarify that the category of troublesome patient is an open one and patients represented in the preceding extract cannot be said to be specifically foreign. In other words the category of difficult patient extends to South African nationals accessing healthcare at the community health centre.

Some patients are classified into this category because they fail to yield to patients who are in worse health conditions than them. The following describes one such case:

> Apparently there was a patient who was brought in an ambulance and she was quick to attend to the patient much to the displeasure of those in the queue. She shares that she took note of the patient who was making the most noise and arguing with her, and much to the amusement of the other staffs she shares that when the patient approached the front desk he had become timid and quite different from the person that he was when confronting her earlier (Field notes 30/09/2009).

The foregoing represents a case where a patient could not make sense of the behavior of the health providers in attending to an emergency. When the patient approaches the front desk they become timid and put on their best behavior. This is interesting because the health provider revels in this show of respect by the patient and to a certain extent reinforces the authority that the healthcare providers command as representatives of the state. As argued elsewhere in this paper, it is worth noting that the health providers feel that in their role as state agents they have authority to determine whether a patient gets healthcare or not. In this case the patient was not informed in ways that he could understand. While the other patients recognised the need to attend to a person in need of emergency treatment, the patient in question could not understand. Such behavior results in the patient being viewed as difficult and lacking simple understanding. This argument does not seek to exonerate the bad mannered patient but to explore the role that the lack of understanding and respect for procedure on the part of the patient could result in problems at the interface. The troublesome patient is often contrasted with a good patient who is portrayed by Anderson as:

> Recognising his or her helplessness and lack of knowledge and accepts the professional authority of medical staff, accepts the spatial and temporal regulations of the institutions (2004: 2009)

The good patient represents the ideal patient that the frontline healthcare providers would like to have at the community health centre. This type of patient is not always easy to find but the citizen patient is quite close to the ideal and the troublesome patient occupies the furthest position from the ideal.

5.2.3 Connected Patient

During fieldwork at the community health centre the researcher observed instances of people coming to the front desk and getting service without standing in the queue, a practice that could be interpreted as being connected or known to the service providers. In one of the instances the person, who did not look like a patient in the eyes of the researcher walked over to the front desk carrying two files and spoke to the clerk in a conversation that was not clear from where the researcher was sitting. What the researcher could make from the brief initial conversation was an exchange of greetings and the patient asking about the clerk's wellbeing. The connected client passed the files over to the clerk who checked them and held them for a while before giving them back to the client. This left the researcher with only one impression, that there are people who use their influence and networks in accessing healthcare and ameliorating their circumstances. This means that they do not stand in the long queues like the rest of the patients but simply walk straight to the front desk to access service without anyone asking questions. The unfair part is in the fact that some people come to the clinic as early as 5 am in the

morning while others by virtue of knowing someone they are able to come late and still get service ahead of those who came early. This illustrates a certain relationship between the healthcare providers and the clients that is only understood in their own terms and is not a written code that is enforced by the institutional management. It is something outside of the legislation and outside of acceptable practice but it continues to happen day in day out. Personal relations are therefore 'a social resource that people employ to achieve specific goals' (Anderson, 2004: 2009). What makes this instance of particular interest is the way that the frontline healthcare providers construct and ridicule the stubborn patients. The treatment of the connected patient could be contrasted with the reaction to one foreign patient who did not want to stand in the queue and the way he was dealt with contrasts sharply with the way the connected patient was treated. Preferential service seems to be only reserved for the connected patient, the disabled patient and the frail patient. This shows the specificity with which the frontline staff defines the parameters of their engagement with the clients and make sure that they can only favour certain categories of patients and not others. On closer analysis it emerges that there are instances of corruption on the part of the front line service providers. The corrupt tendencies are related to the issuing of doctors' letters as evidence of sickness at the places where the patients work. There are migrants who report that they can pay for a doctors' letter even when they are not sick. During the field work the researcher did not observe any incidences of people paying to get sick notes but one staff member disclosed that he was once arrested for issuing a doctor's letter to a patient under unclear circumstances. He shared that he was reported by a work mate but the police did not detain him, they just questioned and released him.

5.2.4 Foreign Patient

Landau and Haupt (2007) argue that anti – foreign sentiment does not only exist at the street level but is also ingrained in the political system and buttressed by sentiments from politicians. The most notable has been the former minister of home affairs (1994 - 2004) and Inkatha Freedom Party leader (IFP) Mangosuthu Buthelezi who categorically spoke against and labelled the SADC ideology on free movement and freedom to choose place of abode and trade as a threat to South Africa (ibid). In light of the foregoing it is important to note that the foreign patient at the community health centre is not like the citizen patient. Apparently the healthcare providers think that the majority of patients that access healthcare at the community health centre are foreigners and the likelihood of some of them causing problems is very high. This could not be verified as the healthcare providers do not write down the nationalities of clients but rely on their own perceptions to come up with numbers of foreign patients. The list that is compiled by the facility statistician at the end of each month also does not reflect the nationalities of the patients coming to the health centre which makes it difficult to have reliable figures on the actual numbers.

The frontline healthcare providers report problems with the foreign patients and allege that the foreign patients use different names at the front desk. The following caption describes some of the challenges that the frontline staff face in dealing with migrants:

> He reiterates what the other participants have shared in response to the problem of shifting identities of the foreign patients. The patients, especially Zimbabweans have names for work, and names for the clinic

> in addition to their real names. He says that, it is the same thing with addresses; the person comes today with an address that they will not even remember tomorrow when they claim to be new visitors (Field notes: 2009/10/7).

The researcher observed 2 instances where patients' requests to have a different name written on the doctor's letter were declined. This use of different names had been confirmed by the frontline healthcare providers as shown in the preceding extract and continues to be an issue in the interaction between healthcare providers and migrants.

> The interesting thing for the frontline staff is that the migrant patients use fraudulent SA IDs at their work places and would want to have a different name written on the doctor's letter to prove that they have been sick at work. The frontline staff report that they sometimes do fill in the different names but on the whole have a zero tolerance on such issues (Field notes, 2009/09/25).

The preceding extract illustrates the dilemma that the healthcare providers grapple with in trying to balance the roles of state agent and citizen agent (serving the interest of migrants). The point is that the healthcare providers are caught in between the demands of the institution that do not allow for such actions and the need to assist the migrant. The behaviour of the healthcare providers as shown in the preceding extract contradicts the statement presented in the section on the uninformed patient that the healthcare providers would create a file for a patient whether he has been to the institution or not. There is no uniformity in the perspectives of the frontline healthcare providers which illustrates a certain measure of inconsistence and discretion in dealing with certain circumstances. The point is that

the handling of such situations is governed less by what the rules say but by what the frontline healthcare providers think is appropriate on that particular day.

Drawing from the perspectives of the healthcare providers it is plausible to argue that in addition to the increased workload that the foreign patient brings to the interface, he/she is likely to have problems speaking the common languages (Zulu, Sepedi and English) spoken by the frontline healthcare providers. The foreign patient is often contrasted with the citizen patient and his or her demeanour conflated with that of the troublesome patient.

5.2.5 Citizen Patient

From the observations and interviews with the frontline healthcare providers and migrants it emerges that there is a category of patients that is less problematic and well behaved. The South African national appears to be set apart as the ideal patient that frontline staffs are willing to attend to. Of importance is the fact that this patient in the eyes of the staff brings fewer problems to the front line. In fact they are least likely to have attitude problems and the language is a given, they surely understand Zulu and therefore will have much to talk about when they come to the front desk. The construction of the South African patient as a law abiding citizen and in constant opposition to the deviant Zimbabwean and foreign patient invokes images of what Landau describes as 'nativist idioms' (2006: 125). These are grounded on the realisation of an autochthonous citizenry that belongs and exists side by side with a denationalised allegory of the non nationals who are in 'nowhereville' (ibid). These nativist idioms are

part of the post apartheid project of nation building that seeks to find commonality in difference and this is helped by the presence of non nationals who often present an archetype of what is not South African and therefore accentuate the boundaries of 'the' South African. The dual imperative of foreignness described by Landau characterises foreigners as simultaneously serving a dual purpose:

> 'First, as scapegoats they help provide convenient explanations for widespread crime, disease and unemployment and more significantly, a reified and dehumanised foreign "Other" underscores South Africans' shared connection with one another and the national territory' (2006: 127).

Furthering the argument on nativist idioms Harper and Raman cite the argument of Rajaram and Grundy – Warr (2004) that:

> "As the refugee lies at the threshold of the nation state, her discursive recreation helps give coherence to the imaginary boundaries of a political community" (2008: 14)

The category of the citizen patient is defined and constructed in opposition to the foreign patient and accentuates the boundaries of what is South African and what is not South African(Harper and Raman 2008). This is buttressed in the argument that political context can play a role in the determination of healthcare access (Walt and Gilson 1994, Schneider et al 2006).

5.2.6 Zimbabwean Patient

During the course of the study the research observed, what could be called 'the pathologisation' of the Zimbabwean patient and creation of an allegory of disease personified by the neighbours from the north. The Zimbabwean patient could be conceptualised as being in a web of multiple exclusions at the hands of the healthcare providers. To start with, they fall into the foreign patient category by virtue of being from outside South Africa and in addition to being foreign they are Zimbabwean. This is not to pay special attention to the Zimbabwean patient but to reflect on the statements used to describe people from Zimbabwe. In one of the interviews, a frontline healthcare provider made a remark that Zimbabweans are cursed because of the lies they tell to the frontline staff;

> Zimbabweans tell too much lies here, God will surely curse you if you do not tell the truth (interview with frontline staff at HCHC, 2009/10/28)

The Zimbabwean patient according to the frontline healthcare providers does not only bring disease to South Africa but is also cursed and is likely to deny his/her nationality and pretend that he/she is South African. The following summary from a conversation with one of the staff members illustrates this point.

> The female frontline healthcare provider appears to be visibly irritated about migrants from Zimbabwe, especially when it comes to the lying part. She says "these people are liars, they lie about their identity, their address, everything; it's all lies" (babuwa maka mani, habatsibi kubuwa nete – Tswana version of the above statement (Field notes, 2009/09/28).

The most notorious on this score are those of Ndebele[40] descent from the south western parts of Zimbabwe. The nature of their treatment worsens only when they pretend to be South African but they generally suffer less discrimination because of their ability to speak Ndebele which belongs to the Nguni group of languages and has the same language structure as Zulu. It is important to note that the circumstances of the Ndebele and Shona[41] ethnic groups are different and distinguished by the ability of the former to communicate in Zulu and the latter's incomprehension of either Zulu or Sotho. A Shona speaking person who does not have good command of the English language is most likely to face problems at the clinic as he/she is deprived of the space to describe the nature of the ailment in the language that he/she is most conversant. The Zimbabwean patient as constructed by the healthcare providers does not only frequent the clinic and use fraudulent documentation but is likely to bring his or her relatives to access healthcare at the clinic because access to primary healthcare is free and the requirements not stringent. One of the first things that were alleged by the frontline healthcare providers during the research was the case of Zimbabweans being bussed all the way from Harare to specifically access healthcare at the HCHC. This contradicts findings by Vearey et al (2009) and discussions in the MHF that migrants do not necessarily come to South Africa as health migrants but have health needs like the rest of the South African population. These needs arise through their continued residence in the country rather than being the primary drivers of migration. The service providers were adamant that the buses that come from Zimbabwe bring patients every Thursday to access treatment at the institution. This issue was reported by all the frontline healthcare providers who participated in the study and informs the gravitation towards negative sentiment on the part of the frontline healthcare providers because of a perceived flood from the north that threatens to overwhelm

[40] The Ndebele share linguistic, cultural and kinship affinity with the Zulu of South Africa
[41] The Shona are the largest population group in Zimbabwe

their capacity to provide services. In addition to bringing disease, using fraudulent documentation and lying about his or her address, frontline healthcare providers allege that the Zimbabwean patient is likely to come to the clinic with a multitude of ailments. This point is illustrated in the following extract from field notes:

> The frontline healthcare providers also mention that one person can come with up to seven ailments and the firm belief is that there is some caucus meeting before someone comes to South Africa. The meeting could include other sick relatives, neighbours and friends, and they discuss the planned visit of a sick member of the family who must carry[42] the diseases of the other sick relatives and get medication at the HCHC. The not so well relative or sometimes the fit one come to South Africa and is diagnosed with 7 illnesses with the hope of getting medication for all of them (Field notes 2009/09/25).

From the preceding extract it is plausible to argue that, the Zimbabwean patient has been set apart and constructed as the most deviant from a list of categories that define and distinguish different patients. Zimbabwean migrants themselves confirmed that the incidences of people telling lies are common but doubted the veracity of fellow countrymen reporting up to 7 ailments. When all the factors are combined, the logical conclusion is that attitudes are informed by the socialisation and cultural orientation that the frontline healthcare providers have. The point is that the street level healthcare providers approach the interface with perceptions that eventually have a bearing on the way they handle the interaction with the Zimbabwean patient. The defining of patients works as a boundary setting mechanism on the part of the bureaucrats as members of society and with a duty that they

[42] Carrying disease here is used in a metaphorical sense rather than literal

allocate themselves to safeguard the boundaries of the nation state and having discretion on the allocation of resources.

5.2.7 Membership and Belonging in the Provision of Healthcare Access

The development of categories to which patients are classified invokes images of a migrant population that does not belong and whose membership is conditional. As noted in the section on language based discrimination, a mistake by the migrant patient is a sign that there is something wrong with the migrant and perhaps it is because of their place of origin that they have made the mistake. This point is best understood in the context of the differential treatment of the South African patient and the migrant patient. Shotter (1993) posits an interesting argument that human action is uncertain and as such an individual is bound to fail in one thing or the other. Shotter further argues that while failure is common, the problem arises when there are certain groups for whom failure does not seem to matter. For instance, the failure to produce an I.D. by a South African national can be overlooked by the health providers because they possess what Shotter calls "unconditional membership"(ibid: 194). This unconditional membership entitles them to support from the health providers even when they fail. The failure to produce an identifying document by a foreigner on the other hand is proof that he/she does not belong and lacks qualification. In terms of Shotter's terminology these are the people with conditional membership. The membership is contingent on the individual putting on the best behaviour in their interaction with the health providers. According to Grove and Zwi migrants are conferred with deviance and in the terms of the autochthonous citizens:

> They do what we don't, they are what we are not, thus forcing choice between us or them, legal or illegal, genuine or bogus. Othering not only creates distance between 'us and them', but also creates a sense of opposition and conflict, that leads inevitably to 'us against them' (2005: 1937).

The lack of full membership creates anxiety and uncertainty in the minds of the migrants accessing healthcare at the clinic. It is within this anxiety of not belonging that researchers could find answers to some pertinent questions regarding the use of fraudulent documentation at the clinic. The feeling of inadequacy and not belonging on the part of the migrant is by its very nature a construction and forces the migrant patient to live within a narrative that they cannot claim to be theirs (Shotter 1993; Grove and Zwi 2006). This argument is not meant to undermine the agency of the migrants but to highlight the potency of the categorisation that goes on at the street level. The categorisation has the effect of creating definitions of what constitutes good and bad behaviour at the point of intersection between the healthcare providers and migrant clients. This is reinforced by the constant reminder noted in the attitudes of the staffs when they treat foreign patients. There is always a tendency among the frontline staff to set apart the citizen and the non citizen as the healthcare providers sometimes tell patients that they are doing them a favour when they treat them. Membership and belonging therefore become important determinants of the healthcare that an individual gets, and deciding factors in the distribution of resources and sanctions by the frontline healthcare providers. In advancing this argument it is worth noting that membership and belonging are best summarised as proximate rather than immediate and stand alone factors in the decision making process. The point here is that, while these factors have the power to influence decision making at the street level they act in combination with other factors.

5.2.7.1 Health Condition as a Contributing Variable in the Treatment of Migrants

In addition to the various categories at the point of intersection the health condition of the patient plays a significant part in the provision of service. The important considerations made relate to the seriousness of the ailment and the extent to which the disease could be contagious. During the fieldwork there were two cases of interest that the researcher observed. One was the case of an individual who was in a wheel chair owing to a serious ailment that had rendered him immobile. The patient in the wheel chair got served ahead of other patients because he was accompanied by one of the health providers who explained the seriousness of his condition to the other health providers. The other case related to a migrant patient who had chicken pox[43]. The migrant patient had to wait in the queue with all the other patients until he accessed the front desk. It is important to note that there is no procedure to screen patients in order of the seriousness and nature of their ailments while they are in the queue. Those that do not join the queue are either brought by an ambulance or they require emergency lifesaving treatment. The migrant patient with chicken pox was only treated ahead of the other patients when he got into the queue leading to the consulting rooms. In these two instances the health condition becomes an important variable which the health providers consider in an attempt to curtail the spread of infectious ailments and the possibility of having people die in the queue. In as much as there is resentment of foreigners at the institution by certain health providers there is a semblance of professional ethic that governs the response to particular cases. This behaviour could however be interpreted as inconsistent based on reports that some people on account of being foreign are made to wait for longer hours than South Africans at the community health centre (HRW 2009b). Situations like

[43] An infectious disease that causes blister like sores all over the body

these were not observed during the field work as patients join the queue regardless of where they come from. There could be exceptions as detailed in the section on the connected patient but the point is that cases mentioned by the HRW are not the norm at the community health centre.

5.2.8 The Contribution of Categories to Migrants' Access (or Lack of) to Healthcare

The use of categories at the community health centre is a factor that does not function alone but works in combination with other factors to limit the opportunities that the migrants have to freely access health services. While the categories used at the front desk constitute variables in migrant access to healthcare, it is not all frontline healthcare providers that openly subscribe to these stereotypes. This is possible owing to the recognition that stereotypes can be separated from personal beliefs and understood as conceptually distinct cognitive structures (Devine 1989). The argument to separate the categorisation of patients from individual healthcare providers is informed by the observation that it is not all the health providers that subscribe to the different categories observed at the health centre. In light of the foregoing it is important to distinguish two levels of analysis, i.e. the individual frontline healthcare providers as a group and the healthcare providers as individuals. This is possible because categories and stereotyping behaviour at the interface assumes the properties of a whole which is greater than the sum of its parts. The implication here is that even without personally subscribing to the categories the said frontline healthcare providers unconsciously perpetuate the ascription of these stereotypes on the personhood of the different patients coming to the point of intersection. With respect to the categories it is also plausible to posit that they are an extension of the bureaucrats'

technical innovativeness and recourse to negative behaviours that permeate the interface (Moore 1987, Nkosi et al 2008). This happens especially when the perceived work load is quite burdensome and in the case of Hillbrow community health centre is considered to be 'too foreign'. Following the argument on the separation of categories from personal beliefs, Devine (1989) argues that the stereotype represents an acquired and perpetuated way of viewing a prejudiced group. In this instance it could be any of the categories that have been alluded to in the foregoing discussion.

Pepper (1947) argues that categories and meaninglessness are used by man as a means to avoid giving evidence for anything believed to be a matter of fact. The creation and understanding of categories as universal, is at best an instrument of dogmatism by the people that use them. In this instance they are made to appear unquestionable and by implication they blind people to the evidence before them. In the terms described by Pepper they become an instrument of dogmatism and by implication they are unquestionable and enduring. By their very nature the categories created at the interface are based less on evidence than sentiment about a particular group of people. While categories gain some permanence and indestructibility as they become widely used within a particular setting they characteristically lose richness and significance (Pepper 1947). What is meant here is that they become applicable more as general rather than specific to certain circumstances and individuals which create other problems as well. The problems that come with this kind of scenario are that people are not seen for what they are and who they really are but the vision and sights of the service providers are blurred by what exists in their minds. They see the illiterate patient, the Zimbabwean patient, the citizen patient and all the other categories before seeing the individual. This point is best illustrated by a statement from one of the frontline healthcare providers:

> "Batho bakoZimbabwe bayatshwana, babowa maka fela" (people from Zimbabwe are the same, they speak lies only) – clerk at HCHC, September 2009

The preceding statement suffices the lack of a clear distinction of human action into individual analogies. Such statements are common at the street level because the healthcare providers are allegedly presented with the same cases from the same nationality. The cases detailed by the healthcare providers range from false addresses to false nationality data and with time the healthcare providers associate such behaviour (lying) with a certain nationality because of the frequency with which it occurs. The following extract illustrates this point:

> She says Zimbabweans constitute the majority of patients who come without documents and most of the times lie about their identity. They often pretend to be South African citizens and we pick the falsehoods through their language and accent (Field notes, 2009/09/28).

The frontline healthcare providers shared that they can tell a patient's nationality for their accent and failure to speak South African languages well.

When the lying behaviour is the first thing that comes to mind when a certain nationality is mentioned, there is a possibility that such ideas are likely to precede action where people from certain countries come to the point of intersection. In promulgating the argument on the relationship between prejudice and action, Shenkin (1974) contends that it is not enough to use prejudice as a rationalising ideology for deeds already done but to understand that it has some effects on action. The argument put forth by Shenkin buttresses the position of this research that prejudice comes before the frontline healthcare

providers' action and is best understood in the formulation of stereotypes that impact on the healthcare providers' ability to deal with cases on an individual basis.

Presenting the case for successful co-production between healthcare providers and patients in the implementation of policies Nkosi et al. (2008) argue that the failure of co-production could have a knock on effect on the behaviour of health providers. The argument here is that the lapse of the bureaucrats into street level coping mechanisms such as labeling and rudeness are a result of the failure of co-production between the street level bureaucrats and their clients. Such failure, according to Nkosi et al could prompt a vicious cycle of negative behaviours and attitudes on the part of both service providers and patients. Simply put, an instance of intransigence by either the patient or the health provider could result in unnecessary arguments with the result that patients end up not getting the desired assistance or deprived of quality treatment. Therefore the lack of understanding at the interface is an important factor that can result in poor relations between patients and healthcare providers. Such cases result from the lack of information amongst some patients with regards to their entitlements and the lack of will power by the healthcare providers to provide the information. Instead the healthcare providers tend to lapse into negative attitude and effectively process the patients into one or more categories existing at the interface rather than clarify issues.

It is important to also note that the categories that are created at the interface are not monolithic but amorphous and subject to constant formulation and reformulation depending on the context and time period. The point here is that it is not uncommon to have a single patient fitting into 2 or more of the

categories. An example would be the Zimbabwean patient who is a foreigner by default and could become a troublesome patient and a corrupt patient by orientation and demeanour. This does not necessarily imply a simultaneous occupancy of the different categories but acknowledges that the cumulative effects of shifting identities among the patients could have this effect. The more common occurrence relates to the cumulative acquisition of the labels rather than the simultaneous qualification into multiple categories.

5.3 The Complexities of the Language Question

The majority of the frontline staff at Hillbrow Community Health Centre speaks Setswana, Sepedi and Zulu. It was observed that the frontline staff use the local South African languages (Zulu and Sepedi) to initiate conversation and it is only when the patient shows a lack of comprehension that they change to English. This could be explained by the presence of a greater number of people with some knowledge of Zulu accessing healthcare at the institution but is by no means supposed to be the sine qua non of exclusion. Speaking in the local languages is both an advantage and a disadvantage to the frontline service providers; it is an advantage in that they are suited for the service of the South African public that generally speaks or understands one of the two or both languages. It becomes a disadvantage to both the healthcare providers and the patients in a migrant dominated context like Hillbrow community health centre, primarily because the frontline healthcare providers are unable to elicit the information they require from the patients who cannot converse in the local languages, and the patients are unable to comprehend what they are asked by the staff.

The issue of language and cultural difference leaves room for miscommunication and dissatisfaction which in turn contribute to sub optimal care and unequal access by the migrant patients or the culturally different. Discussions in the Migrant Health Forum (MHF) with members of the Refugee Nurses Association (RNA) suggest that there are cases of people who do not access health services, not because they do not have need but because they are afraid. This is in reference to refugees and asylum seekers from the Democratic Republic of Congo (DRC) who speak French as their secondary language and a host of other native languages. In such cases, language becomes the single most potent barrier to healthcare access as some people would not go to clinics unless they make arrangements to have someone who is conversant in English accompany them. In addition, categories and concepts used by migrants to explain health problems may differ significantly from South African understandings of what constitutes certain ailments.

The case of one migrant from Malawi captured some interest during the field work for this research and underlined the need to have a public health sector that caters for all people within its catchment areas. The following is a description of what transpired:

> The Malawian migrant could not speak English and was having a difficult time conversing with the health providers. Knowing that Malawi uses English as its official language, I was surprised that he could not speak English but my interpretation of the frontline interface broadened to include categories of patients who are not only disadvantaged in the aspect of language but also are illiterate. One of the frontline health provides tried to get through to him using the East African Swahili language without success and the conversation had to be a bit part affair. Apparently, the migrant patient only spoke Chewa[44] and had a

[44] Chewa is a native Malawian language

> faint understanding of English and could hardly understand Swahili either, meaning that attempts by the staffs to understand him came to nought (Field notes, 2009/09/22).

This was at the front desk where the health providers only require basic information about a particular patient and the type of complaint that they have. The problem must be worse in the later stages of treatment where the patient has to explain the genesis and development of the ailment to a nurse or doctor. A sister at the community health centre shared a case in which the patient only spoke French and the doctors struggled to get through to him. One doctor from West Africa had to use sign language to try and make a diagnosis. Apparently he would point to parts of the body and have the patient affirm or disagree in making a diagnosis. In being only one of the many cases where the doctors struggle with the language question it highlights the need for an inclusive and more comprehensive language policy. The question to ask is; does the healthcare provider make the correct diagnosis in his or her consultation with the patient? If not, then what are the consequences of such neglect? The point here is that the difficulties with language are not limited to the front desk but go beyond and increase in complexity and consequence as the patient goes through the system.

Burton and John – Leader (2009) argue that there is often a difficulty in organising and making a one size fits all communication message where refugees and other migrants are placed within an urban or semi urban context. This suffices the difficulty in dealing with a segmented refugee and worse still a migrant community that is so diverse like the one that South Africa and Johannesburg in particular have. Looking at the health status and living conditions of migrants in Europe, Mladovsky (2006) observes that there

are three groups of factors that curtail migrant access to healthcare in the host countries. These include, stringent requirements for obtaining permanent residence status; literacy, language and cultural differences, and administrative and bureaucratic factors (Mladovsky 2006). While the other two subsist in the South African context, for the purposes of this discussion attention will be focused on the literacy, language and cultural group of factors. Mladovsky argues that in client - provider encounters, 'language and literacy are the most obvious cultural obstacles to providing good quality care' (2006:10). Studying access barriers in the USA Ku and Flores make the point that

> language barriers impede access to healthcare, compromise quality of care, and increase the risk of adverse health outcomes among patients with limited English proficiency (2005: 435).

In the case of HCHC the preceding argument could be understood to mean the lack of Zulu proficiency. It emerged from this research that there is a lack of language policy in South African hospitals and primary healthcare centres that caters for the presence of migrants. It is a surprise omission in the elaborate health policy documents of the South African government given the fact that migrants have been around for a long time. Perhaps it is the downside of apartheid policies and the hangover that still lingers on the minds of policy makers who are fixated on the global appeal of the English language to the neglect of difference. In other words if you do not speak Zulu or Sepedi you must speak English. If not then you are excluded from medical care and other societal benefits that accrue to those who speak and belong thereof to the South African community. Exclusion here implies the lack of fit between the patient and the healthcare system and extends to include the lack of full participation in activities that could require South African language competence on the part of the migrants.

Referring to the case of South Africans, Schneider et al posit that findings from other research activities suggest that, 'minority linguistic communities struggle to communicate within, and access, full services in South Africa' (2006: 13). Similar findings have been documented by HRW (2009b) and CoRMSA (2009), and represent a trend that distinguishes the quality of service and the allocation of discriminatory behaviour patterns according to ethnicity. Lack of belonging and exclusion is not only the problem of foreigners but ethnic minorities as well. However as argued elsewhere in this paper the discrimination becomes worse for those at the extreme end of the language continuum and distinctly foreign in every respect. The issues that affect migrants and ethnic minorities have led to the argument by Schneider et al that inequity[45] continues to be a key feature of the South African health system.

The lack of professional interpreter services could have a negative impact on the realisation of patients' rights as stipulated in section 6(1) of the national health act of 2004[46]. Subsection (2) of section 6 stipulates that:

> The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy.

[45] In defining inequity, Schneider et al make use of Whitehead's (1992) definition that it is the presence of avoidable and therefore unfair inequalities in the distribution of access to health care in populations

[46] Act number 61 of 2003: National Health Act, 2004.

5.3.1 Coping with the Language Difficulty at the Frontline

> The other point of crisis is the language and to overcome this some patients bring their own interpreters, have someone who knows English write the details of their illness on a piece of paper and take the paper to hospital. Sometimes fellow countrymen in the crowd interpret and some colleagues have devised standard greetings with the help of patients (HCHC interview 30/09/2009).

As a result of the language difficulties and the failure of the South African state to recognise the permanence of its migrant population, many health care providers rely on other patients, family members (sometimes small children), friends, and untrained nonclinical employees or non fluent health care professionals to communicate with their patients(Mladovsky 2006; Derose, Bahney et al. 2009). Ku and Flores (2005) sum up the dilemma of the service providers in making the argument that thousands of patients face language barriers every day because of the lack of hospital language proficiency. The reliance by healthcare providers on the mechanisms highlighted in the foregoing have implications for the health of the patients because of the risks that include misdiagnosis, medical errors and poor quality care (ibid: 435).Apart from using other patients as interpreters, the healthcare providers have devised innovative ways of coping with the language difficulties. The following extract details some of the attempts by healthcare providers:

> Sara[47] tries some Shona words; standard greetings and some basic questions to ask patients who can't speak English. She is struggling but seems to be trying her best; she also tries some Swahili and a bit of Lingala (Field notes 2009/11/23).

The preceding text details the innovative ways that have been devised by the healthcare providers in attempts to circumvent the lack of language competence at the health centre. The healthcare providers ask patients from different countries to write down some standard greetings for them. These papers are then used as guidelines in asking some basic question and getting vital information from the patients. This strategy is used at the front desk and is least effective because of the difficulties that the healthcare providers have in pronouncing the words properly. Drawing from the above it is plausible to argue that the language problem will continue to be a serious hindrance to the full utilisation of services by the migrants. Language impacts on the degree of fit between the migrants and the healthcare system as it is a component in the factors on both the supply side and demand side of the access to healthcare triangle (Schneider et al 2006, Penchansky and Thomas 1981)[48]. Language also acts as an important determinant of nationality in cases where patients pretend to be South African. The healthcare providers claim that they can distinguish between a South African and a non national through the accent and the way words are pronounced.

[47] Not her real name

[48] For more information on the access triangle see the section on the concept of access to healthcare in this document (2.4).

5.4 Conclusion

Patient categories and language complexities are important factors in the determination of the degree of fit between migrants and the healthcare system. This has implication for the provision of optimal healthcare and the possible gravitation to language based discrimination by the healthcare providers and differential access to healthcare by the migrants. The use and effect of categories is best summarised in the words of Anderson when he posits that in the Ghanaian hospital he studied:

> Some patients are treated with attentive kindness and respect while others are made to wait, are treated with impatience and discourtesy, given less information and accorded less time. They are ordered around, yelled at, accused of lying and other things (2004: 2005).

The application of courtesy and attentive kindness is specific to certain categories at the interface and creates a continuum of the variation of treatment of different patients. The language question and the patient categories have both immediate and proximate implications for migrant access to healthcare at the community health centre. The immediate effect is that certain patients could be denied access to treatment based on the specific category to which they have been assigned and the lack of language competence at the interface. The proximate implication is that the sum of the actions of the healthcare providers combined are enough to dissuade would be patients from coming to the health centre as well as those subject to negative treatment not returning. The use of patient categories has shown the capacity of healthcare providers to act as reflective actors rather than mere puppets of the health bureaucracy (Giddens 1984). This shows the agency of the providers in going beyond the requirements

of the institution and creating a miniature bureaucracy within the bureaucracy replete with a microcosmic subculture of labeling (Rynbrandt 2005). The agency is also portrayed in the ability of the frontline healthcare providers to find ways of dealing with the language difficulty outside of institutional provision. This adds to the microcosmic repertoire of service provision from which the reflective agents of social action (frontline healthcare providers) draw the resources to deal with migrant patients at the interface.

Chapter Six: Conclusion

This chapter discusses the different conclusions drawn from the research and how the research informs the broader discussions on street level bureaucracy and access to healthcare in South Africa.

This study has shown that decisions made at the front desk have an impact on the ability of migrant patients to exercise their rights in accessing healthcare at the community health centre. The circumstances of both the migrants and frontline healthcare providers have been summarised into the access triangle model which breaks down access into understandable dimensions such as accessibility, affordability, availability and accessibility (Schneider, McIntyre et al. 2006). This model takes into account variable factors that act on both the supply side (health system) and the demand side (migrants) to establish areas of fit which involves an interaction between the factors in the demand side and the supply side (Penchansky and Thomas 1981, Schneider et al. 2006). In terms of this understanding, issues of healthcare providers' attitudes and working environment have been summarised into the supply side as impacting on the ability of migrants to freely access healthcare at the community health centre. Migrants' attitudes and agency has also been understood to impact on the factors that work on the demand side of the spectrum and also impact on the decisions made by the healthcare providers at the point of interaction.

The access triangle provided the valuable tool through which the factors that leverage the possibilities available to migrants were understood and subsumed under the broader analysis of street level

behavior patterns. The theory of street level bureaucracy provided the lens through which the behaviours of the healthcare providers could be understood. In summary the behaviours of the healthcare providers could be seen as conscious and reflective as they have been shown to have the capacity to switch from one role to the other as both citizen and state agents. This argument has been substantiated through the classification of migrants into the category of citizens as represented in their interaction with healthcare providers and the assumption that they are the common client in these interactions. Occupying the role of state and citizen agents can be best summarized as a contradiction of roles at the street level, as the healthcare providers are often intent on performing their duties while at the same time they are caught between their personal interest and those of the state. In straddling the line, the healthcare providers have also shown that their actions to a certain extent can be conceptualized as self serving rather than serving the interests of either the clients or the state as the coping mechanisms that are deployed such as negative attitudes and labeling are drawn from the healthcare providers' prejudices rather than from the rules and procedures laid down by the state.

In all the circumstances attendant to the interaction between healthcare providers and migrants it emerges that there is a continuum of discrimination and kindness that is mediated by language and other markers of nationality and migrant identity. The continuum ranges from the ability to speak Zulu at the apex to the inability to speak Zulu and English at the bottom. The groups that lie in between are the South African minority ethnicities and the foreigners that can speak Zulu such as the Ndebele of Zimbabwe and other foreigners that can speak English. These groups of people dotted along the continuum face differing levels of discrimination and 'attentive kindness' from the healthcare providers (Anderson 2004). The continuum can also be applied in the service of patient categories with the

Zimbabwean patient at the bottom and the South African patient at the top. The South African patient receives what Anderson (2004) calls 'attentive kindness' while the other groups receive less and less of this depending on their positioning along the continuum. The differentiated treatment therefore underlines the argument that documents are not an important determinant in the decisions made by the frontline healthcare providers to either provide or deny access to both documented and undocumented cross border migrants. It is important to make the argument that the differentiated treatment of patients impacts on the quality of healthcare received by migrant patients and for health outcomes to improve in the broader spectrum, healthcare providers ought to treat patients equally, regardless of nationality and patient category.

While the utilisation of interface analysis, the access triangle and the theory of street level bureaucracy in approaching the point of interaction between healthcare providers and migrants yielded the desired understanding of the interface and how it influences healthcare access for migrants, the study could have done more. The point here is that the study had its own limitations which included the lack of comprehensive data on interactions beyond the front desk as these interactions have emerged as important factors with potential to impact negatively on migrants' ability to use the public healthcare system. This provides areas of consideration for future research work in public health institutions and underscores the need to look into health bureaucracies in totality rather than in small segments though this could require more resources which this research did not have.

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APPENDICES

Appendix 1: Health Care Providers Interview Guide

- What is the scale or number of migrants seeking medical treatment at this facility on a daily basis?
    - Of these, what proportion is undocumented or irregular?
    - Which countries do the migrants frequenting this facility come from?
    - Do you give health services to undocumented migrants?
    - If so, which health services do you give them?
- To the best of your knowledge; what rights do migrants have to access healthcare services in this country?
    - Which health services in particular are they entitled to?
- There have been reports in the media and research reports that cross border migrants are sometimes denied primary health care services. Does this happen here?
    - If it happens; what is normally the reason for this?
    - Have you ever been in a position where you had to deny treatment to a patient because they did not have identity documents?
    - How often do you find yourself in this position?
    - Does this also happen with undocumented South Africans?
    - What do you do in the case of South African nationals; do you give them treatment or not?
    - How do you differentiate between nationals and non nationals if they both do not have papers?
- What do the following documents mean to you? Do you refer to any of them in the decisions you make regarding the provision of healthcare to undocumented migrants?

- The national department of health directives of 2006 and 2007
- The Gauteng department of health directive of 2008
- The constitution of South Africa.

Appendix 2: Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)
R14/49 Moyo

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER H0 90808**
PROJECT	Street level bureaucracy: The client - bureaucrat interface between health personnel and undocumented migrant patients at an inner city public health clinic in Johannesburg
INVESTIGATORS	Mr K Moyo
DEPARTMENT	Forced Migration Studies
DATE CONSIDERED	14.08.2009
DECISION OF THE COMMITTEE*	Approved Unconditionally
NOTE:	

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

DATE 09.09.2009 **CHAIRPERSON** .....
(Professor R Thornton)

cc: Supervisor : Dr LN Carrasco

DECLARATION OF INVESTIGATOR(S)

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

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

_____
Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 3: Registration Form Used By Frontline staff

G.P.-S. 11/01 TPH 25 (81/502727)

OUT-PATIENT AND/OR CASUALTY DEPARTMENT

HOSPITAL .....

Name in full .....

Residential address .....

.....

Marital state ..... **Gender** ..... **Race** .....

Occupation ..... **Age** .....

Name and address of employer/Person responsible for payment of account:

.....

.....

Name of sick fund..... S/F No. .....

* Annual family income from all sources:

Breadwinner..... R .....

Wife..... R .....

Other dependants..... R .....

Total..... R.....

* Number of persons in household (including breadwinner).....

State ages of dependants .....

Reason for dependence .....

(* Minor children of 16 years and older who are self-supporting are to be excluded.)

Date of accident/injury..... Time.....

Sent in by ..... Signed .....

Admitting Officer .....

The nature of the patient's illness may be disclosed for accounting purposes.

Witness..... Signed.....

Date .....

Complaint

Present illness

EXAMINATION/TREATMENT/PROGRESS

Date	

Continued overleaf

Patient No.			
	Date	**a.m.**	**p.m.**
Admitted			

Classification.....

Dr. .....

FOR COUNTERFOILS ONLY
(Receipt and account)

Date	Date	Date

Appendix 4: NDOH Revenue Directive

DEPARTMENT OF HEALTH
DEPARTEMENT VAN GESONDHEID
Private Bag X828
PRETORIA, 0001
Republic of South Africa

UMNYANGO WEZEMPILO
LEFAPHA LA MAPHELO
Privaatsak X828
PRETORIA, 0001
Republiek van Suid-Afrika

Faks/Fax : (012) 312-0759
Telefoon/Telephone : (012) 312-0550
Navrae/Enquiry : Ms. U Le Roux/ x0550
Verw/Reference : BI 4/29 REFUG/ASYL 8 2007

REVENUE DIRECTIVE- REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT

To: PROVINCIAL HEALTH REVENUE MANAGERS
HIV/AIDS DIRECTORATES

19TH SEPTEMBER 2007

Dear All

HOSPITAL FEES: ASSESSMENT OF REFUGEE / ASYLUM-SEEKERS (with or without a permit)

Preamble

REFUGEE ACT, Act No. 130 of 1998 (Chapter 5; Section27, (g))

RIGHTS AND OBLIGATIONS OF REFUGEES (Protection and general rights of refugees)
27. A refugee-
(g) Is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time.

To avoid contravening patients rights, as precepts to the Constitution (section 27 (3)) and the Refugee Act: **Act No. 130 of 1998 (Chapter 5; Section27, (g))**

1. **Where refugee status have been determined or asylum seekers with or without a permit:**

1.1. Basic Health Care:

1.1.1 Refugees / asylum seekers **with or without a** permit that do access public health care shall be assessed according to the current MEANS test. (as specified in the Annexure H).

AIDS HELPLINE
0800-012-322
Join the Partnership Against AIDS – Our Actions Count

1.2. Anti-retroviral treatment (ART)

1.2.1 Refugees / asylum seekers **with or without a** permit that do access public health care, shall be exempted from paying for ART services irrespective of the site or level of institution where these services are rendered. ***(Please refer to the ART directive: BI/429/ART dated the 20th April 2007).***

2. Full paying patients:

2.1 The following full-paying patients **are excluded** from free services (basic Health Care and ART) irrespective of the level of care where the service is being rendered:

2.1.1. Refugees / asylum seekers whose income **exceeds** the prevailing means test shall be levied at the full paying UPFS.

2.1.2. Externally funded patients, including members of medical schemes registered in terms of the Medical Schemes Act, 1998 (ACT No. 131 of 1998).

2.1.3. Externally funded patients whose medical schemes **are not recognised** within the RSA scheme pool shall be charged as full paying patients (Self Funded), unless prior arrangements have been made.

2.1.4. Patients treated on account of other state departments, e.g. Compensation Commissioner (COID), SA Police Services, Department of Correctional Services.

2.1.5. Patients treated in state facilities by their **private medical practitioner.**

NB: The execution of this directive is with immediate effect.

Your co-operation would be appreciated.

MR. FG MULLER

CHIEF FINANCIAL OFFICER (CFO) (NDOH)

AIDS HELPLINE 0800-012-322

Join the Partnership Against AIDS – Our Actions Count

Appendix 5: Gauteng Department of Health Memo

Department of Health
Lefapha la Maphelo
Departement van Gesondheid
Umnyango we zeMpilo
OFFICE OF THE CHIEF DIRECTOR
JHB-WEST RAND REGION
ENQUIRIES: MS C KULA
HEALTH PROGRAMMES
TEL: 011 694 3822
FAX: 011 694 3815

MEMORANDUM

TO : All HOSPITAL CEO's, DISTRICT FAMILY PHYSICIANS AND DISTRICT MANAGERS.

DATE : 04 APRIL 2008

SUBJECT : ACCESS TO THE COMPREHENSIVE HIV AND AIDS CARE INCLUDING ANTIRETROVIRAL TREATMENT.

It has come to my notice that some facilities are denying patients that do not have a South African Identity document access to the comprehensive HIV and Aids care, management and treatment plan including antiretrovirals.This practice is not acceptable.

Kindly note that no patient should be denied access to any health care service, including access to antiretrovirals irrespective of whether they have a South African Identification document or not.

For reference please see attached memorandum.

DR. PMH MADUNA
CHIEF DIRECTOR
REGION A

Office Number 119, 1st Floor, Hillbrow CHC Building,
Corner Klein & Smit Street, Private Bag X21, Johannesburg, 2001
Tel: (011) 6943710 Fax: (011) 694 3815