‘The struggle over ideas’:

Investigating how policy processes affect the health & wellbeing of migrant farm workers in Vhembe District, South Africa

Abstract

International, or cross-border, migration has become a particularly contentious topic globally. As a result, policies to curb and limit movement, as well as the rights to which those who move have access, have proliferated. One such key right to which the access of cross-border migrants is consistently limited is public healthcare[1]. South Africa, which is host to various cross-border migrants and in which a great number of South African nationals move across provincial and district borders, is a key example of a country in which non-nationals enjoy a constitutional right to health. However, despite legislation to the contrary, their access to healthcare is pervasively curtailed. In some instances this is explicit, as when provincial Departments of Health (DoH) have issued policy directives stating that healthcare facilities must charge non-nationals when they access primary healthcare, in contravention of the *Uniform Patients Fee Schedule* (Makandwa & Vearey, 2017; Stevenson, 2019). At other times, however, the inability of health policies and programmes to take into consideration the mobility and movement of patients limits the access that non-nationals, as well as South Africans on the move, have (Vearey, Modisenyane, et al., 2017). As such, those who move for work, to seek safety, or simply return home for Christmas struggle to access the health system as and when they move, due to the failure of the state to embed population mobility ‘as a central concern in the design of health interventions, policy, and research’ (Vearey, Modisenyane, et al., 2017, p. 90). In order to support the call for migration-aware and mobility-competent health policies and programming, through which population mobility would be embedded in the health system, developing an improved understanding of the policy processes around such contentious and political issues is imperative.

While theories of policy process exist, they have primarily been developed in and for High-Income Countries (HICs) in North America and Europe (Pierce, Peterson, Jones, et al., 2017). In addition, frameworks that have been used within Low- and Middle-Income Countries (LMICs) function primarily as ‘theoretical checklist(s)’ (Gauvin, 2014), and as such, struggle to provide conceptual understandings of the process(es) witnessed. An improved conceptual

[1] In this context, public healthcare refers to the state run, biomedical health system to which all South Africans and non-nationals from the Southern African Development Community (SADC) currently have access.

understanding of these processes is necessary in order to (a) understand why current responses are limited and (b) work to improve them.

In an attempt to develop an improved conceptual understanding of policymaking in the South African context, characterised by mixed-migration flows and xenophobia, this PhD uses a case study of interventions that were developed and implemented to improve the access that migrant farm workers had to healthcare in general, but HIV care in particular, in Musina, a South African municipality bordering Zimbabwe. As such, this PhD seeks to address the lack of conceptual understanding of the ways in which responses to migration and health in South Africa specifically, but LMICs more generally, contexts within which international non-governmental organisations (iNGOs) are relied upon in healthcare provision, are developed.

In 2008, in response to a cholera outbreak and an increase in the number of Zimbabwean nationals moving across the border into South Africa, iNGOs, including Médecins Sans Frontières (MSF) and the International Organization for Migration (IOM), moved into Musina. After the initial crisis had dissipated, both organisations looked to implement longer-term, more developmental programmes to improve the access that migrant and mobile communities in the area had to healthcare. One such community, with which both organisations decided to work, were migrant farm workers. In 2010, a study by the IOM indicated that HIV prevalence within this community was 28.1 per cent, almost double that of Vhembe District (the district within which Musina is located) – 14.7 per cent (International Organization for Migration, 2010). Access to healthcare for these workers was constrained by their geographical isolation, the resultant financial cost of accessing public healthcare, and their status as non-nationals.

In response, MSF developed and implemented a mobile clinic programme, called the Musina Model of Care and the IOM trained a cadre of community-based healthcare workers – Change Agents – and developed the Vhembe District Migrant Health Forum (VDMHF). However, given the nature of iNGO intervention, as time- and crisis-bound, neither organisation has remained involved with these interventions. MSF left the area in 2013, and the IOM have, since 2017, brought to an end their migration and health programming in the area.

In 2013, MSF handed the Musina Model of Care over to the Vhembe District DoH. In 2017, the IOM, which still has an office in Musina, handed over the VDMHF to the District and brought an end to their support of the Change Agents who were imagined as being self-sustaining. Since the departure of MSF and the IOM's withdrawal from migration and health programming in the area, all three interventions have struggled due to a lack of material resources and political support.

Within this context, qualitative research was conducted between 2016 and 2018 to develop an improved understanding of the policy processes at play during the development and implementation of these programmes. Methods used included the analysis of grey literature in the form of policy, as well as grey literature pertaining to the development, implementation, and sustainability of the programmes; key informant interviews; participant and non-participant observation.

Four key themes emerged from this data. The first is that access to the social determinants of health that would positively impact the health and wellbeing of this migrant community is poor. The second is that within this context, state responses to migration and health are crisis-bound and targeted, rather than proactive and comprehensive. Non-state interventions too are primarily in response to moments of crisis. As such, they are timebound, localised, and not politically supported by the state, creating issues for programme sustainability. Finally, local responses, in the form of community-based healthcare workers, can form part of a migration-aware response to health. However, the reluctance on the part of the state to formally integrate such workers into the DoH undermines this potential.

Finally, a conceptual analysis of the data and these themes was undertaken and has allowed for the development of an understanding of the policy process in South Africa. In response to several tensions that emerged from the data in relation to existing theories and frameworks, this approach takes into consideration the realities of policy making in LMICs, which includes taking into account the presence of iNGOs.

This PhD contributes towards an improved understanding of migration and health in South Africa, specifically with regards to the experiences of migrant farm workers. In addition, it shows how current responses to migration and health undermine the access that both non-national and South African migrant and mobile communities have to healthcare, undermining efforts to meet global health targets, including Universal Health Coverage (UHC). The development of a conceptual understanding of current responses and their limitations allows for a series of lessons to be drawn for future advocacy efforts. Efforts to encourage the development of migration-aware and mobility-competent health policies and programming are increasingly important as the South African state moves to further restrict documented migration into the country and implement a National Health Insurance (NHI) that would drastically curtail the access that non-nationals currently have to the public healthcare system. In addition, although the development and publication by the World Health Organization (WHO) of a Global Action Plan (GAP) for *Promoting the Health of Refugees and Migrants* is

admirable, important work remains to ensure that states develop health responses that take into account the realities of migration and mobility.