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Africa Centre for Migration and Society (ACMS)

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2018
https://hdl.handle.net/10539/29379

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Abstract

For many, migration is a livelihood strategy and contributes socially and economically to the receiving and sending communities and for these benefits to be realised migration has to be managed in a healthy way. Despite this fact, there are negative perceptions about migration globally and in South Africa, particularly cross border migration. Many continue to see migrants as a threat that needs to be contained. Migrants are seen as overwhelmingly many; as a burden on national resources including healthcare facilities; as criminals; and as migrating solely for health seeking purposes. These are unjustified claims without empirical basis. Negative perceptions concerning migrants lead to challenges in accessing primary health care facilities. Sub-Saharan Africa constitutes about 70% of HIV/AIDS cases globally and a greater proportion of these are in South Africa. Non-communicable diseases have also been on the rise in the region and in South Africa. Migration, both internal and cross border, is a significant phenomenon in South Africa pre and post-Apartheid and human mobility, in a context of high disease incidence, has to be considered in policy. Programmatic interventions in the country do not sufficiently engage with population mobility and many migrants face challenges in accessing healthcare services. Service provision and practices at the local level do not always correspond with the little policy that exists. Limpopo, a province in South Africa that borders neighbouring Zimbabwe, is home to a significant number of cross border migrants. This study aimed at investigating whether interventions which involve grassroots NGOs and state primary healthcare facilities in Makhado Municipality, Limpopo, consider human mobility and whether the individual behaviours of workers of organisations and government facilities involved in primary healthcare service provision and gender based violence services influences whether and how these services are provided to migrants. The study also sought to investigate the source of the observed behaviour. The study harnessed Street level Bureaucracy (Lipsky 1980; 2010) and The Institutional Theory (Scott; 2014) as theoretical tools. Semi-structured interviews were conducted with public healthcare providers and workers of NGOs. Findings reveal that interventions do not explicitly consider human mobility and provision of services to migrants is uncoordinated and relies upon the discretion and empathy of the service providers. NGOs provide services on the basis of their own observation and discretion, and not in response to explicit programming on population mobility. State public healthcare facilities also do not have programmes that consider migration. Whilst the nurses' holding of negative perceptions about migrants was consistent with that observed in literature, they reported not denying services to migrants owing to their

cultural and religious persuasions. The study concludes that the provision of services to cross border migrants should not be based on the conscience and mercy of the services providers; it should rather be based on organised coordinated responses and frameworks that consciously and deliberately engage with population mobility.