'The struggle over ideas'[1]:

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

Ph.D. Dissertation

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February 2020

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[1] Stone, D. (2012). *Policy paradox: the art of political decision making* (3rd ed). New York: W.W. Norton & Co. p.13

Declaration

I declare that this thesis has been composed by myself and that the work has not been submitted for any other degree or professional qualification. I confirm that the work submitted is my own, except where work which has formed part of jointly-authored publications has been included. The contribution of other authors to this work is indicated below. I confirm that appropriate credit has been given within this thesis where reference has been made to the work of others.

The paper presented as Chapter 4 was co-authored with Jo Vearey and is currently in press with the *African Journal of AIDS Research*. The paper presented in Chapter 5 was co-authored with Anuj Kapilashrami and has been published with *Global Public Health*. Both co-authors have been supervisors of this PhD project, as well as having been instrumental in the writing of these two publications.

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Thea de Gruchy

27 February 2020

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Acknowledgements

There are many people without whom completing this PhD would not have been possible. I would first and foremost like to thank those who willingly gave of their time to be interviewed, to respond to my emails, and to help me make sense of the various pieces of this research. I would like to thank current and former employees of Médecins Sans Frontières (MSF) and the International Organization for Migration (IOM), local non-governmental organisation employees, Department of Health (DoH) staff - specifically those working in Musina, and civil servants in various other parts of the government, agricultural sector organisations and the farmers who were willing to participate in the research and support me if and where they could. A special thanks in particular to the farm workers and those living in the migrant farm worker communities for their time, given so generous to every new researcher who sets their sights on Musina.

I have been incredibly lucky to have had two supportive and engaged supervisors in Jo Vearey and Anuj Kapilashrami. Both of whom have gone out of their way to ensure that I have had the support I needed during this challenging process.

Undertaking this project has mostly been a happy endeavour. Due to the unwavering support of Jo Vearey and the African Centre for Migration & Society (ACMS), the last four years have been filled with opportunities to grow and develop both personally and professionally. I know that such a holistic PhD experience is difficult to come by and, as such, I am entirely grateful to Jo, Loren Landau, Jean-Pierre Misago, and Ingrid Palmary, for ensuring that the ACMS is an environment in which such an experience can be had. This would of course not be possible were it not for Lenore Longwe, Naledi Mazibuko, and Kwandakwethu Ndaba who are incredibly adept at putting out Wits-related fires and ensuring that the ACMS runs smoothly. Nor would this research have been possible without generous funding from the Wellcome Trust (through Jo Vearey).

Many others have also been instrumental in contributing to the development of this research and my sanity throughout – John Marnell, Becky Walker, Louise McKenzie and Barbara Bompani, Theresa Sommers, Goitse Manthata, Thea Shahrokh, Jodi Wishnia, and Mela Kuch amongst many others.

I would also like to thank Blair Rutherford, Rinse Nyamuda, Learnmore Mvundura, and Edward Govere without whom conducting much of the research with the farm workers themselves would not have been feasible.

I am incredibly grateful for how supportive and loving my family have been over the last four years. Specifically, my mum, who goes out of her way to ensure that anything and everything is possible. Juls, David and Kate, Clare, Clive, Jess, Pete, Jen and Debbie, Gran and Gramps, and Granny Judy – thank you. While my dad isn't here to see this happen, I know he would have been thrilled.

Finally, I have had, met, and made many incredibly friends during this period who have all been incredibly supportive. In particular, I would like to thank Charissa, Dani, Dave, Gemma, Niki-Jay, Rachel and Sophia. Most of whom have been there since the beginning and continue to at least feign interest in the minutiae of my work.

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

[2] 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.

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.

Acronyms and abbreviations

ACF – Advocacy Coalition Framework
ACMS – African Centre for Migration and Society
AIDS – Acquired Immune Deficiency Syndrome
ANC – African National Congress
ART – Antiretroviral therapy
BCEA – Basic Conditions of Employment Act (1997)
CBD – Central Business District
CHW – Community Health Worker
COSATU – Congress of South African Trade Unions
CPC – Centre for Positive Care
DAFF – Department of Agriculture, Forestry and Fisheries
DAH – Development Assistance for Health
DHA – Department of Home Affairs
DHS – District Health System
DoH – Department of Health
DoL – Department of Labour
ESTA – Establishment of the Security of Tenure Act (1997)
EU – European Union
GAP – Global Action Plan for Promoting the Health of Refugees and Migrants
GCM – Global Compact for Safe, Orderly and Regular Migration
CGR – Global Compact on Refugees
GHI – Global Health Initiative
Global Fund – The Global Fund to Fights AIDS, Tuberculosis and Malaria
HiAP – Health in All Policies
HIC – High-Income Country
HIV – Human Immunodeficiency Virus
HREC – Human Research Ethics Committee
IBBSS – Integrated Biological and Behavioural Surveillance Survey
ICERD – International Convention on the Elimination of all forms of Racial Discrimination
IFP – Inkatha Freedom Party
iNGO – International non-governmental organisation
IOM – International Organization for Migration
JMHF – Johannesburg Migrant Health Forum
LMIC – Low- and Middle-Income Country
M+HiAP – Migration and Health in All Policies

MDR TB – Multi-drug resistant tuberculosis
MEC – Member of the Executive Council of a provincial government
MLM – Musina Local Municipality
MOU – Memorandum of Understanding
MSF – Médecins Sans Frontières
NGO – Non-governmental organisation
NHI – National Health Insurance
NP – National Party
NSP – National Strategic Plan
ODA – Official Development Assistance
OHSA – Occupational Health and Safety Act (1993)
OTP – Office of the Premier
PEPFAR – The United States President's Emergency Plan for AIDS Relief
PHAMESA - Partnership on Health and Mobility in East and Southern Africa
PHC – Primary healthcare
PrEP – Pre-Exposure Prophylaxis
REC – Research Ethics Committee
SADC – Southern African Development Community
SALGA – South African Local Government Association
SDGs – Sustainable Development Goals
SDH – Social Determinants of Health
SIDA – Swedish International Development Cooperation Agency
SIZA – Sustainability Initiative of South Africa
TAC – Treatment Action Campaign
TasP – Treatment as Prevention (for HIV)
TAU – Transvaal Agricultural Union
TB – Tuberculosis
UHC – Universal Health Coverage
UK – United Kingdom
UN – United Nations
UNAIDS – Joint United Nations Programme on HIV and AIDS
UNHCR – United Nations High Commissioner for Refugees
US – United States
USAID – United States Agency for International Development
USD – United States Dollar
UTT – Universal Test and Treat (for HIV)
VCT – Voluntary Counselling and Testing (for HIV)
VDM – Vhembe District Municipality

VDMHF – Vhembe District Migrant Health Forum
WBOT – Ward-Based Outreach Team
WHO – World Health Organization
XDR TB – Extremely drug-resistant tuberculosis
ZAR – South African Rand, currency of South Africa

1. Introduction

In recent years, movement across international borders has emerged as a key political and social concern globally. In the United Kingdom (UK) and the United States (US), migration has been a key factor in growing support for right-wing and nationalist politicians (Davey, 2018; Krikorian, 2019; Pencheva, 2019). While in South Africa, in the run up to the 2019 national elections, xenophobic rhetoric was utilised across the political spectrum to garner support and votes within a country increasingly characterised by anti-foreigner sentiment and frequent outbursts of xenophobic violence (Davis, 2019; Griffin, 2019; Mhaka, 2019). Within this global context, cross-border migrants, or non-nationals (the two terms will be used interchangeably in this dissertation), constantly have their rights to services, including to public healthcare[3], contested and limited.

In South Africa, recent police raids and civilian-led attacks on foreign shop owners in the Johannesburg Central Business District (CDB) are an example of the ways in which migrants are positioned as inherently illegal and a burden on the nation state (Bornman, 2019b, 2019c). This is in spite of international frameworks and conventions, like the *International Bill of Rights* and the *International Convention on Economic, Social and Cultural Rights,* and, in many countries, national legislation that codifies the rights that non-nationals have to, amongst other things, healthcare (Bozorgmehr & Biddle, 2018; Wickramage & Annunziata, 2018). While examples in which the rights of non-nationals are explicitly denied or ignored are troubling (for South African examples, see Ndlovu, 2018; Qukula, 2018; Stevenson, 2019), often times the rights of non-nationals are ignored in much less explicit ways. This is most often the case in South Africa.

Here, the rights that non-nationals have to health are articulated in both the Constitution (1996) and the National Health Act (61 of 2003) (the specifics of which are discussed in *section 2.3 (un)healthy migration*). Regardless, these rights are consistently undermined by the failure of the healthcare system to embed population mobility 'as a central concern in the design of health interventions, policy, and research', in other words to be migration-aware and mobility-competent (Vearey, Modisenyane, et al., 2017, p. 90). Consequently, the rights to which migrants have access are habitually undermined through the development of policies and programmes that do not take

[3] 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.

into account the realities of migration, or, as in the case of the recent National Health Insurance Bill (2019) (NHI), actively seek to revoke rights that migrants currently have to healthcare. For example, asylum seekers and undocumented non-nationals from the Southern African Development Community (SADC), currently enjoy the same rights with regards to healthcare as do South Africans. However, under the NHI, these individuals would only be entitled to emergency medical care and treatment for notifiable conditions[4] (National Health Insurance Bill, 2019; Johannesburg Migrant Health Forum, 2016). The particularities of the NHI with regards to migration are described in more detail in section 2.3.

Given the specific research focus of this project, 'migrant' and 'migration' refer to cross-border migrants and migration respectively, unless otherwise specified. However, it is important to note that internal migration – the movement of South Africans across provincial and district borders – is also insufficiently planned for within the healthcare system (Vearey, Modisenyane, et al., 2017). As such, South Africans who move also struggle to access the healthcare services to which they are entitled (Vearey et al., 2016a; Vearey, Modisenyane, et al., 2017).

1.1 Policy processes

Within this context, this project addresses two areas of interest. Firstly, migration and health, and policy responses to issues of migration and health in South Africa. Secondly, policy processes. Through this PhD, I have attempted to make sense of how policies around issues of migration and health are developed and implemented or not developed or implemented – left un-made - through either neglect or design in South Africa. Specifically, given that the South African context is characterised by a poorly decentralised administration and an active array of non-governmental organisations (NGOs), both international and local, working in and around issues of healthcare. As policy engagement with migration is often defined by either a lack of engagement or the development of policies designed to 'fail' (Castles, 2004, 2017; Scholten, 2019), I make use of Sabatier and Weible's proposed definition of policy as anything which 'involves the decisions (including both actions and nonactions (sic)) of a government or an equivalent authority' (Sabatier & Weible, 2014, p. 4). As I show through this research, such an understanding of policy allows for a more accurate understanding of the policy landscape within which my research is located.

In defining 'policy process(es)', I, again, take my cue from Sabatier and Weible (2014)

[4] These are highly contagious diseases, for example polio, typhoid, and rabies (KwaZulu Natal Department of Health, 2019)

and understand a policy process to be 'the interactions over time between public policy and its surrounding actors, events, and contexts, as well as the policy or policies' outcomes.' This resonates with Stone's argument that studies of policy making need to capture 'the essence of policy making in political communities: the struggle over ideas' (2012). As such, a lack of policy on migration and health – policy left un-made – is as much an example of policy making as a policy process that results in legislation or a policy directive. As a case study, an example of the former, policy left un-made, holds vital information about which ideas and interests prevail to the extent that policy is deemed unnecessary. Or, as Stone argues, how realities are framed 'to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation' (Robert Entman, 1993 in Stone, 2012, pp. 252, 253). The use of 'policy process(es)' furthermore allows the processes of 'policy making' and 'policy implementation' to be understood holistically as part of the whole policy process, rather than as discrete events. As such, it allows us to move away from assumptions about policy making as a linear process and bring to the fore the complicated and complex realities that contribute to the shaping of a policy response. For example, the number and variety of actors involved in developing and then implementing policy, including those acting as street level bureaucrats or using migration as a political tool (Crush & Tawodzera, 2014; Misago, 2017; Walker & Gilson, 2004).

'The struggle over ideas' is frequently witnessed around issues of migration in South Africa (Stone, 2012, p. 13). The way in which the agenda – 'the list of subjects or problems to which government officials … are paying some serious attention at any given time' (Kingdon, 2011, p. 3) – is set with regards to migration is often driven by xenophobia. For example, concerns around migration voiced by politicians and in communities in which xenophobic violence occurs are often centred around worries that there are an increasing number of illegal foreign nationals in South Africa (Mhaka, 2019; Modjadji, 2019, p. 24; Willie, 2018). However, according to Statistics South Africa, the national statistics agency, only 3.3 per cent of the South African population are foreign born, while a much larger proportion of the population are internal migrants, a reflection of the global average and broader trends (Statistics South Africa, 2012, 2015)[5]. Research also indicates that both cross-border *and* internal migrants face

[5] Cross-border migrants are disproportionately spread across provinces, with a larger concentration in Gauteng, the Western Cape, and on the Limpopo border with Zimbabwe, than elsewhere. However, while 7.4 per cent of Gauteng's population are cross-border migrants, only 56 per cent of the province's population were born in Gauteng, which means that about 36 per cent of the province's population are internal migrants (Statistics South Africa, 2012). This gives a good indication of the extent to which internal migration is far more prevalent than cross-border migration.

various disadvantages and vulnerabilities during the process of migrating, including within their receiving communities, as factors other than nationality often play a more important role in their experiences (Myroniuk & Vearey, 2014; Vearey et al., 2016a). For example, the length of time spent within the host community has been shown to influence the access that individuals have to healthcare more than their nationality (Vearey et al., 2016).

As with migration, issues around healthcare and healthcare provision are highly politicised in South Africa. As Chigudu argues, in his work on cholera in Zimbabwe, a health crisis is often 'the final stage of a drawn-out, contingent, process rooted in questions of political economy' (2017, p. 40); responses to health are seldom politically or socially neutral (Calhoun, 2010; Chigudu, 2016, 2017). A key South African example of this was the role that political leadership and will, or the lack thereof, played in the lack of a state response to HIV / AIDS prior to 2009 and in the subsequent development of such a response (Mayosi et al., 2012).

1.2 Migration & health

These two highly politicised issues – migration and health - also collide in various ways. In South Africa, this is often around concerns raised by politicians that cross-border migrants come to South Africa specifically to give birth and make use of the public health system, consequently burdening facilities and pushing out locals (Crush & Tawodzera, 2014; Lindeque, 2015; Makandwa & Vearey, 2017). By way of example, in 2018, South Africa's then Minister of Health, Aaron Motseledi - who has recently been made Minister of Home Affairs, the department that oversees the management of international migration in South Africa - made xenophobic remarks about non-nationals utilising the healthcare system (BusinessDay, 2019; Suttner, 2018). There is very little, if any, evidence of migrants, of any kind, overwhelming the South African healthcare systems (Vearey, 2008, p. 128, 2011a) or being detrimental to South Africa in a broader sense (Vearey, 2014). However, these ideas and moral panics persevere, often manifest in xenophobia and xenophobic violence, and have implications for both the lived experiences of migrants and the framing of policy (Crush & Tawodzera, 2014; Misago, 2016; 'South Africa's xenophobia problem', Lawyers for Human Rights).

Due in some part to the ways in which they are framed by political discourse, migrant and mobile populations[6] and communities are often key populations that are

[6] 'Mobile populations can be described broadly as people who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons', while 'migrants are mobile people who take up residence or who remain for an extended stay in a foreign country' (UNAIDS, 2001, p. 3)

neglected or left behind, to use the framing of the *2030 Agenda for Sustainable Development*, by health policies and programming. Examples include 'men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people' – all communities that are associated with higher levels of migration and mobility than the general population and who have traditionally been neglected by health systems (WHO, 2017, p. 1). As noted by the International Organization for Migration (IOM), at least eight of the Sustainable Development Goals (SDGs) hold opportunities to improve the access that migrant and mobile populations have to healthcare and ensure that these communities are not left behind in terms of the *2030 Agenda* (International Organization for Migration, 2018b). However, as this research will demonstrate, the inability of the South African state to develop migration-aware and mobility-competent health policies and programming threatens the country's potential to reach these goals.

In a global context within which many countries have committed to realising Universal Health Coverage (UHC)[7] and meeting the UNAIDS 90:90:90 targets[8], improving the access that such key populations have to healthcare, as well as Social Determinants of Health (SDH) that would improve health outcomes, emerges as imperative[9]. Specifically in South Africa, 'the epicentre of the HIV pandemic', with a national prevalence in 2018 of 20.4 per cent among adults (15 – 49 year) (Allinder & Fleischman, 2019; UNAIDS, 2019). Given the risk that leaving key migrant and mobile populations behind poses for the realisation of these commitments, some governance structures at international, regional, national, and sub-national levels have engaged with migration and health in various ways.

However, these responses often fall short of truly engaging with the imperative of ensuring migrants are not 'left behind'. A recent example of this is the *Global Compact for Safe, Orderly, and Regular Migration* (GCM), 'the first inter-governmentally

[7] A health systems financing mechanism through which 'all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship' (World Health Organization, 2019).

[8] This is an ambitious target and meeting it would mean that by 2020, '90% of all people living with HIV will know their HIV status'; '90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy'; and '90% of all people receiving antiretroviral therapy will have viral suppression' (UNAIDS, 2014).

[9] The SDH framework 'shows how social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors; these socioeconomic positions in turn shape specific determinants of health status (intermediary determinants) reflective of people's place within social hierarchies; based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions' (Solar & Irwin, 2010, p. 5).

negotiated agreement … covering all dimensions of international migration'[10], which 'treats health as secondary to security concerns, and subordinate to the interests of the global labour market' (Bozorgmehr & Biddle, 2018). Alternatively, these responses lose momentum, as in the case of the Southern African Development Community (SADC) *Policy Framework for Population Mobility and Communicable Diseases in the SADC Region*, which has remained as a draft since 2009 (discussed in detail in section 2.3). Or ignore the realities of migration and health, as seen in the South African *National Health Insurance Bill* (NHI) in which the health needs of migrants and their rights with regards to healthcare are simply ignored[11] (discussed in section 2.3). In order to address the realities of the HIV epidemic in South Africa, as well as to meet constitutional and global commitments and improve health outcomes for all, it is imperative to understand why policies and programmatic interventions fail to engage with the realities of migration.

Theories and frameworks of policy processes, that could explain this failure, have, to date and with notable exceptions in public health (Walt & Gilson, 1994), been developed and used in Europe and North American contexts (Pierce, Peterson, Jones, et al., 2017). An analysis of what limited literature does exist on policy making in South Africa (discussed in detail in section 2.5), suggests that trying to understand why and how policy is made and left un-made in the South African context needs to take account of the local and national political contexts, international pressures, ideas, and interests, and a complicated relationship between evidence and policy makers (de Gruchy & Palmary, 2016; Palmary & de Gruchy, 2019). Zimbabwean nationals, living and working on the commercial farms in the Musina Local Municipality[12] (MLM) along the South African border with Zimbabwe, provide the ideal case study through which to further explore policy making in this context; to elucidate key determinants of policy processes in South Africa; and investigate whether existing theories are able

[10] 'Prepared under the auspices of the United Nations', the GCM 'is a non-binding document that respects states' sovereign right to determine who enters and stays in their territory and demonstrates commitment to international cooperation on migration' (International Organization for Migration, 2018a).

[11] The proposed NHI is seen as a response to the state's obligations under the Bill of Rights, Section 27 of the Constitution, to allow the right to healthcare to be realised by all. In its current form, however, the current access to healthcare that non-nationals enjoy in South Africa would be curtailed (Johannesburg Migrant Health Forum, 2016)

[12] In brief, South Africa has three 'spheres' of government – national, provincial, and local (Republic of South Africa, 1998; Siddle & Koelble, 2013). Local government is further decentralised to district municipalities and sub-districts, or local municipalities (the two terms are used interchangeably, although the former is usually used in relation to the DoH). In this example, Musina Local Municipality is one of four local municipalities, or sub-districts, that comprise Vhembe District Municipality (South African Local Government Association, 2017). The complexities of this are discussed in the literature review, sections 2.1 – 2.3.

to make sense of a Low- and Middle-Income Country (LMIC) context[13]. This is given the recent history of Musina as a local context within which policy and programmatic responses to migration and health have been developed and implemented, by both state and non-state actors.

1.3 Research context

Bordering Zimbabwe, Vhembe District has a large cross-border migrant population (see Figure 1). Between 2007 and 2008, a significant number of Zimbabweans crossed the border into the Vhembe sub-district of Musina – an area centred around the border town of Musina – to escape electoral violence as well as a widescale cholera outbreak in Zimbabwe (Rondganger, 2008; Staff Reporter, 2008; Vearey & Anderson, Unpublished). In acknowledgement of the ways in which the municipality was struggling to provide medical care and accommodation to the new arrivals, many international organisations, including Médecins Sans Frontières (MSF) and the IOM, moved into Musina to provide assistance (Vearey & Anderson, Unpublished).

Figure 1: Musina Local Municipality in relation to the region, Google Maps

Once the initial crisis had passed, as both organisations had signed Memoranda of Understanding (MOU) with the state that allowed for their longer-term involvement,

[13] Here I have used the language of Low- and Middle-Income Countries (LMICs) and High-Income Countries (HICs), rather than the Global South/North or more/less developed shorthand. As Ingleby et al (2019) demonstrate, development nomenclatures are inherently limited. However, for the purposes of this research, I believe that the former is a more nuanced reflection of global realities.

organisations turned their attention to other mobile and migrant communities in the area that were deemed to be at increased risk of poor health. One such community was migrant farm workers, predominantly Zimbabwean living and working on the approximately 60 commercial farms in the Musina Municipality (Médecins Sans Frontières, 2012). Research published by the IOM in 2010 indicated that HIV prevalence within this community was 28.1 per cent, nearly double that of Vhembe District (14.7 per cent) (International Organization for Migration, 2010), while in 2008, national prevalence was 10.6 per cent (Republic of South Africa, 2010, p. 22). As such, in 2009, MSF launched an intervention to provide HIV care and treatment to these workers (Médecins Sans Frontières, 2012). Called the Musina Model of Care, the programme consisted of a mobile clinic that would visit ten farms over a two-week period, providing Voluntary Counselling and Testing for HIV (VCT) and antiretroviral therapy (ART) to farm workers who, until this point had had to travel into Musina to access HIV care. For some, this would involve a one-way trip of two hours (see Figure 2), taking time off work, and as such incurring a loss of wages, and the expense of travel[14]. In addition, the healthcare providers on the programme, aware of the mobile nature of this community, provided, among other things, referrals and three months buffer stock of ART to traveling patients[15] (Médecins Sans Frontières, 2012, 2013). The final component of the programme was the training of ten Community Health Workers (CHWs) who, as members of the farm worker communities, could provide community-based support, specifically for HIV positive community members, and basic healthcare on a daily basis, and could act as a link between the workers and the mobile clinic.

[14] Responses varied, but this trip reportedly cost between 60 and 150 ZAR (5 – 12 USD).

[15] Patients who indicated that they were travelling would be provided with three months' worth of stock in the event that they were unable to access ART at their destination and were unable to return within three months.

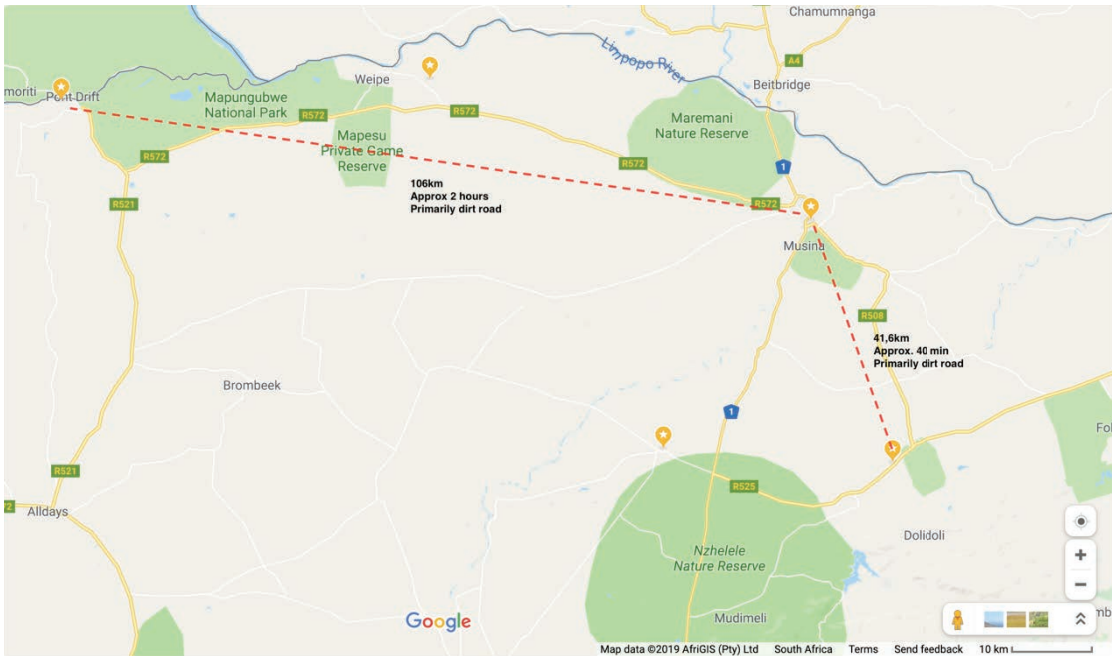

Figure 2: Snapshot of Musina highlighting several of the sites that the Musina Model of Care visits, Google Maps

The programme was able to report an ART retention rate of 90 per cent after 12 months. A retention rate seen more recently in an MSF project in Eshowe, a Municipality in Kwa-Zulu Natal (KZN) Province (Médecins Sans Frontières, 2019a). By way of comparison, the most recent data from UNAIDS indicates that at a national level while 90 per cent of South Africans are aware of their HIV status, only 68 per cent are on ART (62 per cent of all people living with HIV), and only 87 per cent of those on ART are virally suppressed (54 per cent of all people living with HIV) (Avert, 2019). The differences between the MSF projects and the national picture points to the efficacy of community-based initiatives that take into consideration the realities of providing care among specific communities, including the realities of migration and mobility. In acknowledging the success of the Musina Model of Care, MSF report that its legacy:

> from a medical standpoint, is that it confidently demonstrated that it's possible to successfully treat highly mobile cross-border and internal migrants living with HIV (Médecins Sans Frontières, 2013, p. 4).

Simultaneous to the development and implementation of the Musina Model of Care, the IOM, working with the Centre for Positive Care (CPC), a local non-governmental organisation (NGO), as their implementing partner, trained a cadre of over a hundred community-based healthcare workers. Referred to as Change Agents, these volunteers worked across several farms, some of which MSF was also working on. As volunteers, Change Agents were trained to act as peer educators within the farm worker

communities, specifically around issues of health and gender-based violence. This programme was part of the Ripfumelo project that the IOM was implementing in Southern and East Africa. Ripfumelo, which had two iterations Ripfumelo I (2009 – 2011) and Ripfumelo II (2012 – 2015), was part of the IOM's Partnership on Health and Mobility in East and Southern Africa (PHAMESA) (Sibanda & Gititu, 2014). The aim of the projects was to 'provide support to the South African government in its response to addressing migration health concerns in the context of HIV, TB and other communicable diseases' (Ripfumelo II 2012 – 2015 Project Description) and was implemented across several districts in four South African provinces, including Vhembe. The Change Agent programme was a cornerstone of the IOM's Ripfumelo programming in Vhembe and in the final evaluation report of the Ripfumelo project it was noted that:

> The use of change agents as peer educators and information providers in Ripfumelo was premised on the change agents' knowledge of the clients, the fact that they work and live with the targeted client communities (farm workers) support and hence are able to deliver sensitive information in a non-threatening manner. The fact that change agents dialogue with the clients and not teach them engenders a sense of peer support and confidentiality and enables their co-workers to trust them and use the information to change their behaviours. (Sibanda & Gititu, 2014, p. 6)

Additionally, that 'the work of change agents in the farms not only provides timely information but also forums to discussion (sic) troubling issues such as alcohol abuse and gender based violence' (Sibanda & Gititu, 2014, p. 61).

This is within a broader context in which the access that farm workers have to healthcare, as well as protection offered by labour legislation, is limited. Work on the agricultural sector across South Africa has highlighted the poor health outcomes of this population, including that they have a disproportionate burden of HIV (International Organization for Migration, 2010; Kruger et al., 2006; London, 2003) and that health and safety legislation is often not sufficiently concerned with the wellbeing of the worker (London, 1998). Labour legislation, while fairly progressive, is also poorly implemented and regulated in this sector, where wages are low and workers often live on farms, in accommodation, often referred to as compounds or hostels, provided by farmers (Devereux, 2019; Lemke & Jansen van Rensburg, 2014; Visser & Ferrer, 2015; Wisborg et al., 2013).

The MSF and IOM programmes are two of a very small number of interventions,

including those by AgriAIDS and Women on Farms Project[16], that have specifically looked at improving the access that migrant farm workers have to healthcare in general, and HIV care and treatment more specifically. However, while both programmes were initially described as successful by those involved, including MSF, IOM, and civil servants, their sustainability is in question. MSF left Musina[17] in 2013, handing the management of the Musina Model of Care over to the DoH at a District level. While in 2017, the IOM, who still (at the time of writing in November 2019) have an office in Musina, brought an end to their health programming in the area. This ended the availability of funds for both the IOM and CPC to engage with the Change Agents who, the IOM and CPC argued, could continue working as peer educators without external support.

Given this context, Musina provides an interesting case study through which to investigate (a) policy and programmatic responses to migration and health in general, and HIV specifically, and (b) the policy processes associated with the development, implementation, and sustainability of these responses.

1.4 Research question and objectives

1.4.1 Research question:

Given the lack of locally-relevant policy frameworks, and the limited nature of both research on and responses to migration and health, can a case study of policy and programmatic responses to the health and wellbeing of migrant farm workers in Vhembe District, Limpopo inform a conceptual framework that is able to improve understandings of policy processes around migration and health in South Africa?

1.4.2 Objectives:

1. To develop an improved understanding of migration and health within the South African context, specifically of the health and wellbeing of migrant farm workers;
2. To understand how policies on issues of migration and health are framed in South Africa;

[16] AgriAIDS is an NGO that works specifically to improve the access that workers in the agricultural sector have to healthcare, specifically for HIV (NGO_03). Women on Farms Project is an NGO that works primarily in the Western Cape (Devereux et al., 2017).

[17] At the time of writing (November 2019), MSF currently have a project underway in Beit Bridge, a town on the Zimbabwean side of the border, and are initiating a research project across the border in Musina.

3. To investigate the development of policy and programmatic responses to migration and health in South Africa, from agenda setting to implementation, and experiences thereof;
4. To be able to explain, conceptually, why policies are made or left un-made, and in so doing address the limitations of existing frameworks; and
5. Develop an understanding of what improved policy processes might be and reflect on lessons learnt for future advocacy for better policy processes around issues of migration and health in South Africa.

1.5 Thesis overview

This thesis is submitted for examination in line with the PhD by publication standing order, S2016/2229. According to this standing order, four articles are required to have been written: one of these articles is to be published, one is to be in press, the third is to have been accepted, and the fourth is to have been submitted. As it currently stands, paper one is in press (de Gruchy & Vearey, in press), papers two and three have been published (de Gruchy, 2019; de Gruchy & Kapilashrami, 2019) and paper four has been submitted to a journal (details are outlined in Table 1).

These four papers have been written to work together to build a central thesis and theoretical contribution to the literature on policy making and migration and health in South Africa. This will be demonstrated and articulated throughout this dissertation. As such, this thesis proceeds with a literature review, which lays out the various bodies of literature with which this research project has engaged and highlights where and how specific papers have engaged with this work. This is followed by a section on the methods that were used in this project and the various ethical considerations involved in undertaking this research. The four papers follow, each of which is preceded by a brief overview that situates the paper in relation to the other papers and the dissertation as a whole. The articles have been arranged in an order which best creates a narrative around the findings. As such, paper one is *'Left behind': Why implementing migration-aware to HIV for migrant farm workers is a priority for South Africa,* which is currently in press with the *African Journal of AIDS Research*. This is followed by *After the handover: Exploring MSF's role in the provision of health care to migrant farm workers in Musina, South Africa* (de Gruchy & Kapilashrami, 2019), which has been published by *Global Public Health*. The third paper is *Responding to the health needs of migrant farm workers in South Africa: Opportunities and challenges for sustainable community-based responses* (de Gruchy, 2019), which has been published by *Health & Social Care in the Community*. And the final article is *Sustainability and the state: Towards an improved understanding of policy processes, a case study of migration and health in South*

Africa, which has been submitted to *Critical Social Policy*. When these papers are referenced in the chapters comprising this dissertation, I have marked in square brackets to which paper the citation refers. For example (de Gruchy & Kapilashrami, 2019) [Paper two] for ease of reading.

The final elements to this project are the Discussion and Conclusion chapters, in which the findings of the four papers are discussed in relation to one another and I respond to my research objects and questions. In addition, the Conclusion includes a discussion of possible directions in which future research could go. While this research has been underway, a new *White Paper on International Migration* has been published by the state and new ways of managing migration are being explored in South Africa, including a policy of encampment for non-nationals. In addition, the use of xenophobic rhetoric by politicians has proliferated (Bornman, 2018, 2019a, 2019b; Mahr, 2017).

Furthermore, at the beginning of this project, the *NHI White Paper* (2015) had recently been published. Submissions (Johannesburg Migrant Health Forum, 2016, for example) were made in response to the *NHI White Paper*, specifically in relation to its proposal to limit and revoke access that migrants have to healthcare. However, the *NHI Bill* (2019), which was published as I finished this research, reflects that beyond public comment no attempts have been made to amend the proposed NHI to be migration-aware and mobility-competent. Within this dynamic context, this research points to some of the tensions that are likely to emerge as migration and health policy that is developed in South Africa is increasingly anti-migrant and anti-migration.

Table 1: Papers

Paper	Title
1	De Gruchy & Vearey **(in press).** 'Left behind': Why implementing migration-aware responses to HIV for migrant farm workers is a priority for South Africa. *The African Journal of AIDS Research.*
2	De Gruchy & Kapilashrami **(published 2019).** After the handover: Exploring MSF's role in the provision of health care to migrant farm workers in Musina, South Africa. *Global Public Health.*
3	De Gruchy **(published 2019**). Responding to the health needs of migrant farm workers in South Africa: Opportunities and challenges for sustainable community-based responses. *Health & Social Care in the Community*.
4	De Gruchy **(submitted manuscript).** Policy windows, humanitarian actors, & the impenetrable state in South Africa: Towards an improved understanding of policy processes in LMICs, a case study of migration & health. *Critical Social Policy*.

2. Literature review

There are five bodies of literature and areas of research across which this research project cuts. Ultimately, the research question on which this project was predicated is about the policy making process within a context in which multiple spheres of governance are interacting. Within the South African context there are understood to be three spheres of governance – national, provincial, and local – rather than levels. This is understood to highlight the 'distinctive yet interdependent and interrelated' nature in which the spheres operate (Oosthuizen & Thornhill, 2017). In order to examine this process, I engage with literatures and theory that are able to shed light on both the context in question, as well as the kinds of interventions and processes witnessed.

Consequently, this literature review starts with an overview of cross-border migration and its governance in South Africa. The intention of this section is to aid an understanding of the complications of life for non-nationals in the country as a consequence of, amongst other things, pervasive xenophobia[18] - discriminatory attitudes and actions, ranging from the barriers to accessing services to violence, towards non-nationals (Landau, 2012; Misago, 2017; Mogekwu, 2005). This is followed by an overview of the South African health system. While the healthcare landscape in South Africa is characterised by the co-existence of multiple health systems, including traditional African healthcare structures (Golooba-Mutebi & Tollman, 2007) and a highly resourced private biomedical healthcare system, over 80 per cent of South Africans and non-nationals are without medical aid, including migrant farm workers, and are reliant on the under resourced and overburdened public, biomedical, health system (Benatar, 2013; Coovadia et al., 2009; Statistics South Africa, 2017). As such, it is this system with which this project is exclusively concerned. Section 2.2 highlights the complexities of this system and difficulties with which decision makers in the Department of Health (DoH) are faced. This is proceeded by a discussion of the forms of exclusion from this system experienced by cross-border migrants, in spite of their Constitutional right to access healthcare. The fourth body of literature pertains to the role of non-governmental organisations, particularly international humanitarian organisations and supranational organisations, who work with migrant communities

[18] Mogekwu (2005) argues that xenophobia 'is neither indigenous to any particular part of the world, nor alien to any', and is 'akin to ethnocentrism and racism.' It 'is a profound dislike of non-nationals by some citizens of a recipient state. It is embodied in discriminatory attitudes and behaviour towards such non-nationals, and often culminates in violence against them, abuses of all types, and in exhibitions of hatred. In its most explosive form, xenophobia manifests in the killings and ethnic cleansing.'

to improve their access to healthcare in local contexts. The fifth and final body of literature pertains to theories of policy change and process. While this literature frames the overall conceptual grounding of the project, it has been included last in the literature review as I believe that these theories and frameworks need to be read and engaged with in relation to the context in South Africa.

Various parts of this literature are also discussed and expanded on in the four journal articles in which the research is presented. These discussions are not repeated here, but references are made to the papers where appropriate.

2.1 Migration in South Africa

In recent years cross-border migration has emerged as a major political concern across the world; incessantly framed as a 'crisis' by politicians and the media, this framing has contributed to the growing popularity of right-wing nationalism particularly in Europe and North America (Achiume, 2017; Börzel & Risse, 2018; Castles, 2017; Crawley & Skleparis, 2018; Jeandesboz & Pallister-Wilkins, 2016). However, only 3.3 per cent of the global population are in fact cross-border, or international, migrants (International Organization for Migration, 2017). A number that includes asylum seekers[19], refugees, and individuals from Europe and North America engaged in, what Castles euphemistically refers to as, 'professional mobility' (2017, p. 1542). In addition, a far greater percentage of the global population are in fact internal migrants – citizens who move within their country of origin (International Organization for Migration, 2017). These realities are, however, often forgotten as moral panic – discourse that problematises and exaggerates perceived deviance from a societal norm (Critcher, 2008) – often originating in Europe and North America, characterises public and political discourse around migration globally (Androvičová, 2017; Banda & Mawadza, 2015; Bogen & Marlowe, 2017; Emilsson, 2018; Jeandesboz & Pallister-Wilkins, 2016).

These global trends are reflected within South Africa, in which only 3.3 per cent of the population are cross-border migrants, while a much larger proportion of South African citizens move internally (Statistics South Africa, 2012, 2015). Cross-border and internal migrants are however disproportionately spread across the country: cross-border migrants, for example, are concentrated in the urban hubs in Gauteng and the Western Cape, and in Musina, South Africa's northernmost municipality, which borders Zimbabwe (Statistics South Africa, 2012). These migrant dense areas are often represented as the norm, to which the state must respond, as public and political

[19] A legal category describing those who have applied for refugee status.

responses to migration are characterised by unsupported claims about the vast numbers of cross-border migrants making their way into South Africa illegally and with the intention of engaging in criminal activities and overburdening the healthcare system (Banda & Mawadza, 2015; Crush & Tawodzera, 2014; Landau, 2012, pp. 9–11). These claims have most recently been reiterated as justification for a series of state raids and citizen-led attacks on migrants in the Johannesburg Central Business District (CBD) (Bornman, 2019b, 2019c).

While international conventions, protocols, and United Nations (UN) agencies exist through which state responses to asylum seekers and refugees (*Convention Relating to the Status of Refugees*, 1951), trafficked persons (*Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children*, 2000), and migrant workers (*International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families*, 1990), are regulated, 'the governance of migration remains in the realm of state sovereignty' (Pécoud, 2018, p. 1626). As a consequence, while the International Organisation for Migration (IOM), a UN *related* agency branded as the 'UN Migration Agency', has a broad mandate to improve state responses to migration, it is largely dependent on its member states' willingness to engage and on their terms (Guild & Grant, 2017; Pécoud, 2018).

As detailed in Table 2, as a consequence of this, efforts have only recently been made to develop migration policy at a global level. While efforts to form international agreements around migration, for example, the *Global Compact for Safe, Orderly, and Regular Migration* (GCM) (2018), are important, they are likely to be hampered by methodological nationalism; the reliance on nation states to implement the agreed upon provisions and the limited role that the IOM is able to play in regulating this implementation (Newland, 2019). The GCM, described by Newland as 'the softest of soft law', is not legally binding (2019, p. 660). Moreover, it focuses ideas of 'best practice' on border management, demarcating where the responsibilities of one state ends and another begins. In addition, the focus on 'legal' and 'regular' migration ignores the realities of mixed migration flows and continues to allow states the freedom to decide to whom they are willing to provide documentation (Newland, 2019). Such a focus has meant that differences between citizens and non-nationals are amplified and reified, rather than eliminated in line with the International Convention on the Elimination of all forms of Racial Discrimination (ICERD) (Guild, 2019).

Table 2: Key migration policies

	Migration policy Policies that specifically address 'migration', rather than specific kinds of migrants, e.g. refugees or labour migrants
Global	Global Compact on Safe, Orderly and Regular Migration (GCM) (2018)
	New York Declaration for Refugees and Migrants (2016)
Regional African Union (AU) and Southern African Development Community (SADC)	AU Migration Policy Framework for Africa and Plan of Action (2018 - 2030) (2018)
National South Africa	White Paper on International Migration (2017)
	Immigration Act (2002)

In southern Africa, while an AU Migration Policy Framework has recently been published, the failure of the Southern African Development Community (SADC) to generate a strong regional response to issues of development, including migration (Nshimbi & Fioramonti, 2014) and health (Penfold, 2017; Penfold & Fourie, 2015), has meant that little mitigates the nation state-centric nature of migration management in the region. This is discussed in more detail in *section 2.3 (un)healthy migration*. As such, I turn to the management of migration within South Africa.

During Apartheid[20], South Africa had two racially defined, parallel, immigration systems. While the immigration of white population groups was subject to complex policies and concerns (Peberdy, 2009), those who were racially classified as 'black', were isolated in the bantustans[21] and in neighbouring countries and brought into the urban and industrial centres of South Africa under the highly regulated and restrictive migrant labour system[22] (Peberdy, 2009). Post-Apartheid, this has changed; there are no longer two parallel immigration regimes based on racial identification, although many argue that in practice the migrant labour system has simply continued (Crush

[20] Apartheid, described by the United Nations as 'a crime against humanity' in 1973, was the legal system of governance in South Africa between 1948 and 1994. Building on earlier colonial policies and systems, Apartheid intrenched white minority rule and became synonymous with human rights violations against the majority non-white population in South Africa.

[21] 'Officially termed "homelands" by the white state, the bantustans were set up as ethnically defined territories to house South Africa's black population … Between 1951 and 1981, ten bantustans were set up, with six being given the status of a "self-governing" territory … and four eventually holding full "independence" … and thus presenting themselves as autonomous countries' (Phillips, 2017). These territories were formally dissolved and incorporated into the Republic of South Africa in 1994.

[22] The apartheid era migrant labour system was a highly structured process of recruitment, work, and return that moved not only black South Africans across the country, but also workers from the region into South Africa to work in the labour intensive mining industry, as well as in factories and in the commercial agricultural sector (Delius et al., 2014; Wilson, 1972).

& McDonald, 2001; Trimikliniotis et al., 2008). In a bid to move away from this system and legacy, South Africa has enacted progressive refugee legislation in the form of the *Refugees Act* (138) in 1998 (Landau, 2006), and in 2002 passed the *Immigration Act* (13 of 2002). This project is exclusively concerned with cross-border migrant workers, as such those who's movement into South Africa is governed by the *Immigration Act* and its various amendments and regulations. Current changes to this legislation - articulated in the *White Paper on International Migration* – are currently under development.

Reflecting global trends, South Africa's immigration regime – both in policy and in practice – has become increasingly restrictive (Androvičová, 2017; Messina, 2014; Peberdy, 2009; Topulli, 2016). There is consensus that migration can be beneficial for socio-economic development (Nyberg-Sorensen et al., 2002; Ratha et al., 2011; Segatti & Landau, 2011; Vearey, 2011a, 2014), including for health as many migrants are healthier than the communities into which they migrant (discussed in more detail in Section 2.3). However, the body of policy governing migration in South Africa has, by and large, hampered the realisation of many of the developmental benefits of migration. Through a focus on exclusion and bureaucracy, and an insistence on responding to migrants from the region through special dispensations, rather than through inclusive and accessible visa and permit options (Moyo, 2018; Peberdy, 2001, 2009), healthy migration, a pre-requisite for socio-economic development, has been neglected (Vearey, 2014).

In addition, most asylum seekers, for example, are not granted refugee status in South Africa due either to the Department of Home Affairs' (DHA) policy of rejecting asylum claims (Amit, 2011), or the inability on the part of officials at Refugee Reception Offices to recognise claims, specifically, for example, those based on sex or gender discrimination (Palmary, 2016). According to the DHA's own statistics, fewer than one in six applications for refugee status are granted (Gerber, 2019). Furthermore, the new *White Paper on International Migration,* released by the DHA, which suggests the direction in which migration management in South Africa should and will go, lays out an even more restrictive system in which non-nationals from sub-Saharan Africa, and elsewhere, will struggle to access documented entry. Importantly, it recognises the limitations of South Africa's current immigration legislation: its colonial roots; that it does not allow South Africa to 'adequately embrace global opportunities' (2017, p. 2); that 'South Africa has not put in place adequate policy, strategies, institutions and capacity for attracting, recruiting and retaining international migrants with the necessary skills and resources' (p.3); and recognises that SADC 'lags behind' other regional bodies with regards to facilitating the free movement of people and goods

(p.17). However, not only have efforts to develop regional policies been hampered by South Africa, but the proposed new legislation and structures indicate a focus on security and the (unsubstantiated) crime risk that immigration poses to South Africa (see p.35 for an example). As well as a focus on attracting and making movement into South Africa easier for 'skilled' individuals and business people with a history of regulated movement (p.36), while incorporating addition bureaucratic hurdles for 'low-skilled' individuals through additional measures to 'externalis(e)' South Africa's borders (p.36). The White Paper argues, correctly, that this is in line with 'international best practice' (p.36). However, 'international best practice', as envisaged in the GCM and seen in practice, is often insufficiently human rights, or development, focused (Guild, 2019; Pécoud, 2018; Wise, 2018).

Additionally, South Africa's immigration regime, spearheaded by the DHA at a national level, has been plagued by corruption and mismanagement, which has weakened the Department's ability to manage migration (Segatti & Landau, 2011). It has led, for example, to a massive backlog in application processing and the rejection of 96 per cent of applications for refugee status (Postman, 2018). Accessing documentation as an immigrant has become more difficult not only because of the DHA's mismanagement, but also due to recent changes in regulation that have not only augmented the cost of visa applications, but also made the application process more cumbersome and time consuming (de Gruchy, 2015, 2018).

This increasingly restrictive immigration regime has not, however, stopped the state and private sector from making use of non-nationals, documented or not, as cheap and exploitable labour in sectors including agriculture, mining, hospitality, and domestic work (Budlender, 2014; Kiwanuka et al., 2015; Munakamwe & Jinnah, 2015). Within this context, non-nationals are also, by and large, excluded from formal efforts to mobilise workers (Fine, 2014; Munakamwe, 2018; Schierup, 2016). Fine (2014) argues that this is due to South Africa's xenophobic climate, as well as high levels of unemployment and precarity among South Africa trade union members. Within this context, the rights of non-nationals are not prioritised. In addition, Segatti and Polzer (2012) argue that cross-border migrants struggle to mobilise primarily as a result of the divisions within the migrant community as a whole (p. 207 - 209). Munakamwe (2018) however shows that migrants do utilise social media and messaging applications to share information and create solidarity as non-nationals. Although, she concurs that this is largely out of necessity in spaces in which their involvement in formal mobilisation is limited. Regardless of this exclusion, becoming visible through mobilisation may be a serious deterrent to non-nationals due not only to concerns

around documentation, but also given the realities of xenophobia and xenophobic violence in South Africa (Munakamwe, 2018; Segatti & Polzer, 2012).

Xenophobia – 'discriminatory attitudes and behaviour towards … non-nationals' (Mogekwu, 2005) (see footnote 17 for a more comprehensive definition) - has become an increasingly visible force within South Africa. Outbreaks of xenophobic violence are frequent (Anyadike, 2015; Landau, 2012; Leander, 2015) and politicians often blame non-nationals for service delivery failures and rising crime rates (Bornman, 2019b; Misago, 2016, 2017; Nicolson, 2017). However, although migration frequents political discourse across state structures and, arguably, affects the concerns of multiple Departments, including for example the Department of Health (DoH), it is exclusively the Department of Home Affairs (DHA), and in some specific instances the Department of Labour (DoL), that are mandated to respond to migration. A key example here is local government - local and formal state systems in the guise of the municipality or district and sub-district. Local government does not have a mandate with regards to migration in South Africa. However, local government is tasked with a 'developmental mandate': to work 'with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and improve the quality of their lives' (Republic of South Africa, 1998). To realise this mandate is arguably not possible without engaging with population mobility, both cross-border and internal (Blaser Mapitsa, 2019; Landau & Singh, 2008; Vearey, 2010, 2011a, 2011c, 2017).

Furthermore, extending the definition of 'local governance' to 'refer to all formal and informal systems of order in a given locality or polity … all localised *systems of controls'* (p.203) (emphasis in original text), Misago (2016, 2019) shows that local governance is one of the most salient elements in determining if and when xenophobic violence will occur within a community. Misago argues that local governance provides, what he refers to as, 'micro-political opportunity structures' which create openings for xenophobic violence through either the direct facilitation of violence by elected leaders, or the inability of elected leaders to attain legitimacy and the subsequent emergence of 'violent informal leadership groups' who target non-nationals (p. 210, 2011). Consequently, there are multiple opportunities and possibilities for local government to engage with migration, and arguably a necessity for it to do so. However, given both the lack of official mandate and political will, local government is often reticent to proactively engage with migration and mobility (Blaser Mapitsa, 2019; Landau & Singh, 2008; Vearey, 2010).

In addition, Landau et al. (2013) suggest three supplementary factors that act against responses to migration being sufficiently planned for at a local level. Primarily, officials are not rewarded for identifying and trying to allocate budget for additional population groups. This speaks to the second factor – limited budgets. Budgeting for municipalities is done on the basis of Census data, which is, at times, ten years out of date, and does not take continuing urbanisation, internal, and cross-border migration into account. Finally, although South Africa has a constitutionally mandated decentralised government, which should mean that local government could make some policy decisions, and take up the opportunities that its developmental mandate provides (Siddle & Koelble, 2013), policy making largely remains in the hands of the ruling party at a national level (Landau et al., 2013, p. 118, 119). This ineffective implementation of decentralisation has also created problems for the public health system and its governance (Chopra et al., 2009; Steytler & De Visser, 2007), to which I now turn.

2.2 Health in South Africa

The World Health Organization (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO Constitution, 1948). I have used this definition within this research primarily as it acknowledges that health and wellbeing is broader than physical wellbeing and, by extension, requires more than a purely biomedical approach to realise. A reality reflected by work on the Social Determinants of Health (SDH) (Marmot, 2005; Solar & Irwin, 2010); work that highlights the ways in which access to positive determinants of health are hampered by structural, social, and material factors. However, the ways in which health is framed and responded to at both global and national levels reflects a continued preoccupation with biomedical responses to physical ailments (Confortini & Krong, 2015) (see Table 3 for examples). For example, the nine objectives listed under Goal 3 of the United Nation (UN) *2030 Agenda for Sustainable Development*[23] – Ensure healthy lives and promote wellbeing for all at all ages – are all objectives in relation to physical health and wellbeing.

The health-related Sustainable Development Goal (SDG) that has undoubtedly garnered the most attention, including the development of its own Global Compact, has been 3.8 – Universal Health Coverage (UHC):

[23] The Sustainable Development Goals (SDGs) are a collection of 17 goals that were set and agreed to by UN Member States at the UN General Assembly in 2015.

> Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Through the realisation of UHC, it is argued, the other health SDGs can be achieved and no one will be 'left behind' by sustainable development (*Universal Health Coverage: Moving Together to Build a Healthier World—Draft Zero*, 2019).

These debates have a particular salience in South Africa, given the high levels of socio-economic inequality and consequent deeply inequitable access to positive determinants of health across the population (Ataguba et al., 2015; Chopra et al., 2009; Marmot, 2005). This is particularly true for key populations that have traditionally been 'left behind' by health policies and programmes that have failed to sufficiently engage with the particular difficulties that groups like sex workers, men who have sex with men, and prisoners have in accessing positive determinants of health (Desmond Tutu Foundation, 2011; Stuart & Samman, 2017).

Table 3: Key health policies

	Health Policy Health policies considered of relevance to this research
Global	Global Compact on Universal Health Coverage (2018)
	UNAIDS 90:90:90 (2017)
	Sustainable Development Goals, Goal 3 (Agenda 2030) (2015)
	SADC HIV and AIDS strategic framework (2010 - 2015)
Regional African Union (AU) and Southern African Development Community (SADC)	Protocol on Health (1999)
	Policy Framework and Strategy for Ward-Based Primary Healthcare Outreach Teams (2018/19 - 2034/24) (2018)
National South Africa	National Health Insurance White Paper (2015, 2017)
	National Strategic Plan (NSP) on HIV, STIs and TB (2017 - 2022) (2017)
	Community Health Workers Policy Framework (2004)
	National Health Act (2003)

Healthcare provision within South Africa takes place against a long history of health system fragmentation and within a complex environment in which health inequities have been and continue to be aggravated by racial inequalities (Coovadia et al., 2009). Within this context, plural health systems, both traditional and biomedical, exist

(Golooba-Mutebi & Tollman, 2007). With regards to the biomedical systems, a small number of South Africans utilise private healthcare and medical aid schemes, while the vast majority, of primarily black South Africans, are left making use of the under resourced public health sector (Coovadia et al., 2009; Department of Health, 2011; Statistics South Africa, 2017). The public health system (with which this research is concerned) is both under resourced and underfunded (Begg et al., 2018; Rispel et al., 2018), and has been deeply hampered by efforts at decentralisation (discussed in more detail below) (McIntyre & Klugman, 2003). As a result of which, the software of the health system – 'ideas, interests, values, norms, and relationships' (Sheikh et al., 2014, p. 2) – have been neglected, resulting in a lack of workplace trust, job dissatisfaction among healthcare providers, and the haphazard implementation of healthcare policy (Coovadia et al., 2009; Gilson, 2006; Gilson, Palmer, & Schneider, 2005; McIntyre & Klugman, 2003).

Moreover, South Africa is faced with the 'so-called four colliding epidemics' – HIV and tuberculosis (TB); injury and violence; chronic illness and mental health; and maternal, neonatal, and child health (Mayosi et al., 2012). Since late 2009, South Africa has been implementing extensive programmes to address these epidemics; this has included rolling out the largest antiretroviral treatment (ART) campaign globally. However, while the Department of Health (DoH) has made significant strides, South Africa still has high incidence of both TB, including multi drug resistant (MRD) and extremely drug resistant (XDR) TB ('TB statistics | Incidence, prevalence, high burden', 2019), and HIV ('HIV statistics for South Africa | Prevalence, incidence, ARVs', 2019); violence remains rife; maternal and child health are poor (Mayosi et al., 2012); and the burden of non-communicable diseases in the country is growing (Mayosi et al., 2009; Nojilana et al., 2016).

As a response to this context, specifically the pervasive HIV epidemic, as a result of which 7 700 000 South Africans were living with HIV in 2017 (UNAIDS, 2019), South Africa has committed to implementing UHC and meeting the UNAIDS 90:90:90[24] targets through rolling out Antiretroviral Treatment as Prevention (TasP), including Universal HIV Test and Treat (UTT) and Pre-Exposure Prophylaxis (PrEP) programmes. Although calls have been made for responses to HIV, including UTT and PrEP, to be migration-aware and mobility-competent, to date responses that engage

[24] Meeting this ambitious target would mean that by 2020, '90% of all people living with HIV will know their HIV status'; '90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy'; and '90% of all people receiving antiretroviral therapy will have viral suppression' (UNAIDS, 2014)

with migration are lacking (Camlin et al., 2018). Furthermore, in an effort to meet its commitments to Universal Health Coverage (UHC), both as an SDG and Constitutionally[25], the DoH has proposed the introduction of a National Health Insurance (NHI) (Department of Health, 2015). While some have welcomed the prospect of UHC, there is some concern over the implementation of the system in such a complex context within which current systems and structures are struggling. Particularly as the *NHI Bill*, in a similar vein to the *White Paper on National Health Insurance*, which was 'expected to provide finality in a manner which is ready for implementation, including the development of any necessary legislation … leaves many questions unanswered' (Gray & Vawda, 2016). For example, the Paper states that 'a massive reorganisation of the health system would be required to create a new platform for service provision and healthcare financing', which would include changes to the 'functions, responsibilities and relationships within the three spheres of government' (Department of Health, 2015; Gray & Vawda, 2016). While this suggests extensive changes to the structure of the DoH, in its various forms, no specificities have been given as to how this will be undertaken (Gilson, 2019; Gray & Vawda, 2018). In addition, the piloting of the NHI in specific districts is commonly regarded to have been a failure (Genesis et al., 2019). As a reflection of this, there is wide scale concern that the NHI will fall short of 'access to quality essential healthcare' (SDG 3.8) (Rispel et al., 2018).

As it stands, in accordance with the *National Health Act* (61 of 2003) and *Schedule 4* of the *Constitution* (of 1996), the DoH is structured so that major health policy decision making resides with the national DoH, while primary healthcare, hospitals, and most service provision falls under the mandate and control of the nine provincial governments (McIntyre & Klugman, 2003). Primary healthcare, while a mandate of the provincial government is envisaged as being 'rendered under the auspices of district health councils' - local governments, of which there are 52 – who are also mandated to see to 'municipal health services', which 'includes aspects of environmental health care but does not specifically include primary health care' (Steytler & De Visser, 2007). However, municipalities, which were previously tasked with providing primary healthcare were ordered, in 2006, by the courts 'to continue rendering primary health care services until the provincialisation (of health services) has taken place' (*Independent Municipal and Allied Workers Union v President of the RSA, Case no.*

[25] The proposed NHI is also seen as a response to the state's obligations under the Bill of Rights, Section 27 of the Constitution: 'Everyone has the right to have access to health care services including reproductive health care … The State must take reasonable legislative and other measures within its available resources, to achieve the progressive realization of each of these rights. No one shall be refused emergency medical treatment.' (Department of Health, 2015)

3298/2006; Steytler & De Visser, 2007). The changing mandate has created confusion and frustration across district municipalities (Versteeg et al., 2009). In addition, the metropolitan municipalities of Johannesburg and Cape Town take responsibility for healthcare in a manner that circumvents the provincial administration, raising questions about the extent and efficacy of provincialisation nationally.

However, regardless of the extent to which the provincialisation of primary healthcare has taken place, the decentralisation of healthcare has created a serious policy problem. The central premise of decentralisation – that the local sphere of government is best placed, and thus able through decentralisation, to develop policies and programmes for the specific communities that it serves – has largely remained unrealised as the agenda of local government continues to be set at a national level (Landau & Singh, 2008; McIntyre & Klugman, 2003; Siddle & Koelble, 2013). In addition, policies developed at a national or provincial level, specifically within the DoH, are infrequently and inadequately communicated to implementing staff at a provincial or local level respectively, which has led to low staff morale and frustration (McIntyre & Klugman, 2003). Finally, in an effort to save money, the DoH has restricted the hiring of personnel, which has meant that posts often go unfilled and has created serious staff shortages across facilities (Blecher et al., 2017; Daviaud & Chopra, 2008).

Within this context, it is unsurprising that research by Gilson and others has pointed to a distinct lack of workplace trust within the South African public healthcare system (Gilson, 2003, 2006; Gilson et al., 2005). Workplace trust, defined as 'respectful and fair treatment in (the) workplace', is, amongst other things, rooted in 'trust in (the) employing organisation', (Gilson et al., 2005, p. 1421), which, given the lack of engagement by the DoH with "softer issues" of management, including the supervision of staff, is unsurprisingly lacking. This is further discussed and reflected on in relation to this research project in de Gruchy and Kapilashrami (2019) [Paper two].

These various factors have meant that access to healthcare in South Africa is highly inequitable (Gaede & Versteeg, 2011; Goudge et al., 2009; Harris et al., 2011). Those living in rural areas, like the sub-district of Musina, are particularly hard hit by staff and stock shortages and policies which do not take into account the realities of providing care to rural populations (Gaede & Versteeg, 2011). Here, drawing from work by the Commission on the Social Determinants of Health and the World Health Organisation (WHO) (Marmot, 2005; Solar & Irwin, 2010), the public health system

emerges as a key social determinant of health to which many do not have access to (as argued in de Gruchy & Vearey, in press) [Paper one], not only in rural areas but also within urban peripheries and among marginalised groups, such as migrants (Myroniuk & Vearey, 2014; Vearey, 2011; Vearey, 2013a)

One of the key ways in which the poor access to health of these marginalised populations has been addressed has been through the use of community-based healthcare workers. Community-based healthcare worker programmes have a long history in South Africa (Daniels et al., 2012; Friedman, 2005; Nxumalo et al., 2016). Important to note is that much of the literature simply refers to these as Community Health Worker (CHW) programmes. However, due to the existence of various cadre of community-based healthcare workers across the country, and in Musina specifically, with different names and job descriptions, here I use the term 'community-based healthcare workers'. Prior to 1994, these kinds of programmes were usually founded by civil society initiatives concerned about the poor healthcare available to the majority of black South Africans, who 'felt that healthcare provision was inseparable from democracy' and that community-based programmes were 'part of the struggle for democracy' (van Ginneken et al., 2010, pp. 1113, 1114). However, following South Africa's transition from apartheid to democracy in 1994, these healthcare workers were not incorporated into the public health system. Left without their earlier ideological and political motivation, or the state support that had been anticipated, and in an era in which funds which would previously have gone to community-based healthcare programmes and the civil society managing them went instead to the state, many of these programmes have collapsed (van Ginneken et al., 2010, p. 1111).

However, in the late 1990s, in response to the growing HIV/AIDS pandemic and the state's reluctance to address it, civil society and funders returned to community-based healthcare and community programmes began to re-emerge (van Ginneken et al., 2010, p. 1111). Due to the fragmented and disconnected ways in which these programmes developed, a wide array of actors, including peer educators, generalist CHWs, nutrition advisers, and family planning advisers, were trained under the general title CHW (Friedman, 2005). This fragmentation is reflected in the national *Community Health Workers Policy Framework (2004)*, the first policy to address CHWs that speaks to the role of these programmes and their incorporation into South Africa's national health system (Friedman, 2005; Schneider et al., 2008). In the *Framework*, CHW is used as an umbrella term to refer to all 'community/lay workers in the health sector' (Schneider et al., 2008). This policy, and subsequent policies and political decisions,

makes it clear that while the state sees CHWs as important, they remain peripheral to the state (Daniels et al., 2012; Schneider et al., 2008; van Ginneken et al., 2010). For example, the state has committed to pay CHW stipends, but insists on doing this through local civil society acting as implementing partners. These organisations, through state funding, are tasked with training, managing, and administering CHW programmes (Daniels et al., 2012; Schneider et al., 2008; van Ginneken et al., 2010). As is illustrated in paper three (de Gruchy, 2019) as well as in the literature, this process often results in delayed stipend payments for community-based healthcare workers (Schneider, English, Tabana, Padayachee, & Orgill, 2014). In addition, some cadre of community-based workers, again discussed in more detail in paper three (de Gruchy, 2019), continue to be trained as 'volunteers' and are thus further excluded from being incorporated into the DoH structures.

As such, although research indicates that such programmes improve the access that rural communities have to care, the DoH has failed to capitalise on this, and the development, implementation, and management of these programmes is left to non-state actors, negatively affecting sustainability (Clarke, Dick, & Lewin, 2008; Friedman, 2005; Lehmann & Gilson, 2013; Nxumalo, Goudge, & Manderson, 2016; Schneider, Hlophe, & van Rensburg, 2008). As further discussed in de Gruchy (2019) [Paper three], the use of community-based healthcare workers was one of the strategies used by both Médecins Sans Frontières (MSF) and the IOM to improve - to borrow from the language of the four A's - the affordability, acceptability, availability and quality of healthcare to which migrant farm workers around Musina had access (Hausmann-Muela et al., 2003, p. 14). However, even where such programmes are successful, inequities in access to healthcare persist, particularly for precarious communities like farm workers. Access to healthcare for this population needs to be understood within the context of the relationship between the state and the agricultural sector.

2.2.1 Access to healthcare for farm workers

During Apartheid, labour legislation was not extended to the agricultural sector. It was only in 1997 (three years after the end of Apartheid), with the introduction of the Basic Conditions of Employment Act (BCEA), that farm workers were extended the protection of general labour legislation (Visser & Ferrer, 2015, p. 39). Prior to this, wages, occupational health and safety, and access to healthcare were at the discretion of the farmer. As such, rights given to workers through the *Establishment of the Security of Tenure Act (ESTA)* (1997), for example, are seen as a direct threat to the farmer and his business by the state. Attempts by the state since 1994 to protect farm workers thus disrupt historical modes of 'domestic government', a concept developed by

Rutherford to describe white-owned commercial farms in Zimbabwe that I believe is applicable across the border in South Africa (2004; 2017):

> The mode of belonging on these white-owned commercial farms, this domestic government, pivoted around the farmer. For many of the white farmers, it generated an identification with an environmental belonging to the landscape (Hughes 2006), a strong sense of the propriety of private property, and a paternalistic responsibility over the comportment, if not edification, of the farm workers (Rutherford 2004; Hartnack 2015). (Rutherford, 2017, p. 34)

The disruption, or attempted disruption, of this domestic government has threatened, and resulted in the loss of, 'racialised paternalism' (Bolt, 2016b, 2017; Devereux, 2019). Although farm workers are in a far better position now with regards to wages and occupational health and safety than they were during Apartheid, the piecemeal ways in which protection would have been extended to the worker through racialised paternalism have been removed:

> A more general conclusion is that the replacement of racialised paternalism on farms with legislated labour rights has had the unintended consequence of removing non-wage benefits that farmers used to provide informally which have not been replaced, as farmers engage strategies to evade legislation and deliver as little as possible to their workers. What used to be accepted as the responsibility of farmers is now seen as the responsibility of the ANC (African National Congress) government. (Devereux, 2019, p. 20)

However, given the fragmented way in which this sector is governed, the state has not been able to effectively respond to this responsibility. State regulation of the agricultural sector involves multiple departments, and remain largely dependent on farmer's cooperation as noted in de Gruchy and Vearey (in press) [Paper one] as well as in other literature (Devereux, 2019), and is hampered by a lack of resources, personnel, and interest (Visser & Ferrer, 2015).

In addition, while the Department of Labour (DoL) conducts inspections in accordance with the OHSA, healthcare for farm workers is primarily accessed through the DoH. Workers need to access healthcare facilities in nearby towns, although the geographical isolation of farms often renders these healthcare facilities inaccessible. In addition, as detailed in the proceeding section even when workers are able to visit a clinic, access, particularly for non-nationals is not guaranteed .

Before discussing the particularities of healthcare access for non-nationals, however, it is worth noting that many of the frustrations experiences by non-nationals when they (try to) access healthcare are also experienced by South Africans, specifically South Africans who move (Vearey et al., 2016a). Some deliberate efforts have been and continue to be made to deprive non-nationals of the right to access healthcare (see discussion below). However, when seeking care non-nationals and South Africans often face the same challenges given that the DoH is overburdened and under resourced, as discussed above.

While the NHI proposes to rectify many of these challenges for South Africans, beyond practical concerns around its implementation (Gray & Vawda, 2016, 2018), there are questions about the constitutionality of the proposed policy due to its exclusion of healthcare for non-nationals (Johannesburg Migrant Health Forum, 2016).

2.3 (un)healthy migration[26]

Currently, everyone in South Africa, including undocumented non-nationals from SADC, is entitled to free primary healthcare. For higher levels of care, both South African nationals and non-nationals are means tested in accordance with the *Uniform Patient Fee Schedule* in order to determine how much they should be charged (Johannesburg Migrant Health Forum, 2016). One exception is pregnant and lactating women and children under six, for whom all healthcare is free. However, as mentioned, the *NHI Bill* proposes that this access be curtailed. For example, refugees would only be entitled to 'basic health care services' funded through a special contingency fund – a definition or explanation is provided for neither of these concepts, which makes understanding these proposed changes even more complex; asylum seekers and undocumented non-nationals would only be entitled to emergency medical care and treatment for notifiable conditions[27]; and any other immigrant would have to pay in full for any healthcare, even at a primary level (National Health Insurance Bill, 2019; Johannesburg Migrant Health Forum, 2016). Importantly, HIV/AIDS is not a notifiable condition (KwaZulu Natal Department of Health, 2019). As such, non-nationals will be excluded from South Africa's response to the epidemic.

[26] (Vearey & Nunez, 2010)

[27] These are highly contagious diseases, for example polio, typhoid, and rabies (KwaZulu Natal Department of Health, 2019)

These suggested policy shifts reflect global trends which frame migration as a security issue, and the response as restrictive immigration policies, as seen, for example, in the recent *Global Compact for Safe, Orderly and Regular Migration* (GCM) (Messina, 2014; Vearey, 2018) (See Table 4). This is reflected both nationally and regionally in Southern Africa. At a regional level, the South African Development Community (SADC) has drafted a *Policy Framework for Population Mobility and Communicable Diseases in the SADC Region,* which would lead to a more progressive regional response to migration and health. However, since the publication of the draft in 2009, this framework has stalled as several member states, including South Africa, have refused to ratify it. This fits within SADC's broader history of being unable to develop regional responses to migration (see Section 2.1). SADC is largely beholden to the interests of its member states (Penfold, 2017) and, as such, responses to contentious issues, such as migration, are often undermined by powerful member states, including South Africa, and their concerns about non-nationals migrating specifically to utilise, and consequently overburden, their public health systems (Nshimbi & Fioramonti, 2014; Oucho & Crush, 2001).

Table 4: Key migration and health policies

	Migration & health policy Policies that specifically address migration and health
Global	Promoting the health of refugees and migrants: Global action plan (GAP), 2019 – 2023 (2019)
	World Health Assembly Resolution WHA70.15 Promoting the Health of Refugees and Migrants (2017)
	World Health Assembly Resolution WHA61.17 on the Health of Migrants (2008)
	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990)
Regional African Union (AU) and Southern African Development Community (SADC)	SADC Declaration for Tuberculosis in the Mining Sector (2012)
	Policy Framework for Population Mobility and Communicable Diseases in the SADC Region (2009, Draft)

Although the data is limited, what is available suggests that concerns about cross-border migrants overburdening health systems or precipitating ill-health are unfounded (Vearey, 2012). Globally, research points to a 'healthy (im)migrant effect' - those who migrate are often healthier than the local populations into which they migrate (Gushulak, 2007; Kennedy et al., 2015; Malmusi et al., 2010). This benefit is, however, time-sensitive and tends to diminish as migrants struggle to access positive

determinants of health in their host communities (Gushulak, 2007; Kennedy et al., 2015; Malmusi et al., 2010). This is no different in South Africa (Vearey, 2013a, 2014). Vearey suggests that migration affects health through the act of migration, the 'disparities in health risk (including the health system itself) that exist between points of origin and destination' (2013a), and the inability of the healthcare system to understand 'the diversity and disparity of the population' (Vearey, 2013a, p. 127). This includes understanding the various healthcare regimens on which immigrants may already be and the necessity for mobile patients to be able to access their medication as they move for work or simply return home during the festive season (Vearey, Modisenyane, et al., 2017). In addition, access to healthcare for non-nationals is often further undermined by their treatment at health facilities where healthcare providers have been known to deny or delay care to non-nationals, verbally abuse them, and subject them to additional fees (Makandwa & Vearey, 2017; Vearey, 2014). In early 2019, for example, the Provincial DoH in Gauteng issued a directive instructing healthcare facilities to charge all non-nationals, except those with refugee status, in full for all levels of care (Stevenson, 2019). Although this was later withdrawn, given concerns about its legality and pressure from civil society, this is a clear example of the ways in which the rights that non-nationals have to care can be, and are being, eroded.

These realities are reflections of global trends, and have led to migration being recognised as a key determinant of health (Castañeda et al., 2015; Vearey, Palmary, Thomas, Nunez, & Drimie, 2010), an argument that is developed in de Gruchy and Vearey (in press) [Paper one]. In addition, it has lent itself to calls for migration and health to be taken into account in policy making at all levels of governance (Vearey et al., 2019; Vearey, Modisenyane, et al., 2017; Wickramage & Annunziata, 2018). Migration-aware and migration- and health- aware policies and programming – in other words 'a whole-system response whereby population movement (and health) is embedded as a central concern in the design of health interventions, policy, and research' (Vearey, Modisenyane, et al., 2017, p. 90) - are usually called for from a rights-based perspective and point to the failure of states with respect to their international commitments (and often their own national legislation) if and when they fail to ensure equitable access to healthcare for non-nationals (Crush & Tawodzera, 2014; Khongthanachayopit & Laohasiriwong, 2017; Vearey, 2014; Wickramage & Annunziata, 2018). Others have however argued that this approach falls into the trap of pitting the rights of nationals against the rights of non-nationals. Rather, it is posited, the argument for ensuring that migrants have equitable access to healthcare should come from a global public goods (Widdows & Marway, 2015) or a public health ethics position (Tahzib et al., 2019; Wild & Dawson, 2018). The former is essentially a

utilitarian and economic argument that suggests that if the health of all individuals (including migrants) is not protected, the good health of all is under threat. A key example here is around vaccinations and the necessity of acknowledging that immigrants are part of the 'herd' in order to ensure herd immunity (Widdows & Marway, 2015). While the later pushes for an acknowledgement that public health is 'built upon such values of equal human rights and of shared humanity … (and) should thus protect and promote migrants' wellbeing and citizen health alike' (Tahzib et al., 2019, p. 106). A philosophical engagement with this argument is beyond the scope of this PhD. However, the necessity for these arguments points to the dearth of migration-aware and mobility-competent health policies and programming globally. The lack of comprehensive state responses to the health and wellbeing of migrant and mobile communities has meant that responses that exist are primarily implemented at points of crisis, and that they are largely led by humanitarian agencies and development actors.

2.4 The involvement of (international) non-governmental organisations in healthcare provision

2.4.1 The involvement of international actors in South Africa

In many low and middle-income countries (LMICs), including South Africa, non-governmental actors, both local and international, are involved in the provision of healthcare. The range and diversity of the international actors in particular is vast. In order to allow for a clear analysis and discussion of their involvement in Musina, and other local contexts, it is worth understanding the field as comprising of four kinds of actors, including both organisations that form part of foreign governments and independent organisations. I have primarily referred to these actors collectively as international non-governmental organisations (iNGOs) to note their separation from the South African state and from local, South African, non-governmental organisations (NGOs).

The first are state development agencies that provide bilateral Official Development Assistance (ODA) to LMICs. A key example is the President's Emergency Fund for AIDS Relief (PEPFAR), an initiative of the United States (US), of which South Africa has, historically, been a key recipient (Katz et al., 2013). However, as Dieleman et al argue, 'in addition to supporting improvements in global health, it is important to acknowledge that DAH (Development Assistance for Health) has also been a key component of foreign policy for many donor countries' (2019, p. 1; Storeng et al., 2018). In recent years, for example, ODA, specifically from the European Union (EU), has been used to externalise the borders of High-Income Countries (HIC) by tying

development assistance for LMICs to improved border and migration control in these countries. Primarily in an effort to ensure that 'displaced people never get to Europe's borders in the first place' (Akkerman, 2018, p. 2).

In addition, ODA and development agencies, including those attached to the UN (discussed below), are key funders of research around migration and development in South African, and other LMIC, universities, where institutions are chronically underfunded (Landau, 2012). Critiques of this mode of funding highlight how, as a result, 'scholars tend to reproduce the kind of knowledge and analysis aid agencies hope to see … (which) impoverishes the quality of scholarship' produced (Landau, 2012, p. 562). While ODA organisations are tied to the political projects of specific nation states and are therefore inherently governmental, here they are understood as part of the array of non-governmental organisations because they work under the jurisdiction of the South African government while their mandates originate elsewhere.

The second are Global Health Initiatives (GHIs), such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). PEPFAR is often listed as a GHI, however, unlike other GHIs, it is exclusively funded by the US and is a key programme of the US Agency for International Development (USAID). GHIs, 'set up primarily as a mechanism for new funding in health rather than an implementing agency', tend to focus on specific diseases and bring together a wide range of actors (Kapilashrami & Hanefeld, 2014, p. 163).

The third are intergovernmental organisations, including United Nations (UN) agencies, like the United Nations High Commissioner for Refugees (UNHCR), and UN related agencies, like the International Organization for Migration (IOM) (Pécoud, 2018; The International Organization for Migration, 2016). Formally governed by their member states, such organisations need to balance the need to respect state sovereignty and push their own political agenda or, in the case of the IOM, the agenda of more powerful member states (Pécoud, 2018).

The fourth, and final group for the purposes of this project, are humanitarian agencies, for example Médecins Sans Frontières (MSF) and the International Committee of the Red Cross. Traditionally, these organisations have responded to crises caused by conflict and natural disasters through providing short-term, "politically neutral" aid (see Lischer, 2005; Redfield, 2013 for a discussion understandings of aid as politically neutral). However, organisations like MSF are increasingly taking on longer-term

developmental projects (Carruth, 2015; Fassin, 2010; O'Brien et al., 2010; Redfield, 2010, 2012a, 2012b, 2013). Historically and particularly with respect to how organisations understand and position themselves, there has been understood to be some distinction between the two (Crewe & Axelby, 2013). However, Crewe and Axelby note:

> If 'development' is used for attempts to produce long-term social, economic or political change then, in contrast, 'humanitarian aid' responds to disruptions and emergencies, such as war, famine and natural disasters, with an emphasis on the short term. But the boundaries are blurred: development usually involves some shorter-term aid - helping the poorest families out when they are destitute - and humanitarian aid often aims for longer-term service provision. (2013, pp. 3, 4)

These agencies are often comprised of local chapters, with varying oversight from headquarters in cities like Brussels or New York. And while historically they have worked in contexts in which the state and service provision from the state is largely absent, increasingly such organisations are working alongside governments. A key example of this has been in South Africa, where organisations like MSF have had to learn how to 'operate in coalition' with the state, as well as other civil society (Redfield, 2013, p. 246). This has raised questions about the role that they play, and should play, in local contexts, some of which are further discussed in de Gruchy and Kapilashrami (2019).

Traditionally, this range of actors have been recognised as 'a valuable source of technical and financial input', due to their freedom from state structures and commitments to innovation (Bedelu et al., 2007). However, increasingly 'the benevolent dictatorship of humanitarian government' (McFalls, 2010) is being critiqued. Concepts that legitimise the involvement of humanitarian agencies in a context, like "emergency", "crisis", "medical" and "humanitarian" itself, concepts that have been understood by some, including humanitarian organisations, to be politically neutral and legitimise the 'moral economy of humanitarian interventions' (Fassin, 2010), are increasingly being recognised as socially and politically constructed and contested (Calhoun, 2010; Chigudu, 2016, 2017; McFalls, 2010). These critiques are discussed further in section 2.4.3.

2.4.2 Local civil society

In addition to the range of INGOs and as a consequence of the anti-Apartheid struggle in South Africa, the civil society sector in the country is fairly well developed, particularly in comparison to other countries in the region (van Zyl et al., 2018). As such, a variety of NGOs work across the health sector. Some of these NGOs are primarily involved in activism and advocacy. A key South African example is the Treatment Action Campaign (TAC). During the Mbeki administration (1999 – 2008), the South African government's response to the HIV/AIDS epidemic was characterised by denialism. In response, the TAC undertook a range of activities, including mobilising local communities and litigating against the state, across the country to demand access to HIV care and treatment for HIV positive individuals (Heywood, 2009). Other NGOs however function largely as implementing partners for either the state or international organisations. NGOs of this kind are often beholden to the agendas of the organisations funding them (Ahmad, 2006; Ghanotakis et al., 2009; Lewis, 1998) or tied to complicated relationships with government departments (Rosenberg et al., 2008). Many such organisations are involved in the administration of Community Health Worker (CHW) programmes (discussed in more detail in de Gruchy, 2019).

2.4.3 Challenges associated with the current iNGO model

Given this wide array of different organisations with their own organisational mandates and agendas, the well documented lack of co-ordination within this sector is unsurprising (Hill, Dodd, Brown, & Haffeld, 2012; Kapilashrami & Hanefeld, 2014; Klingebiel, Negre, & Morazán, 2017; Pfeiffer, 2003). At various points, attempts have been made to address this 'excessive fragmentation of aid at global, country or sector level [that] impairs aid effectiveness' (Paris Declaration, 2005). Most notably, the Paris Declaration of 2005 that argued that 'a pragmatic approach to the division of labour and burden sharing increases complementarity and can reduce transaction costs' and called for improved harmonisation of the activities of non-state actors involved in aid and development. In 2008, this was reiterated in the *Accra Agenda,* which called for the reduction of 'the fragmentation of aid by improving the complementarity of donors' efforts and the division of labour among donors'. And again, in 2011, at the 4th High Level Forum on Aid Effectiveness in Busan, South Korea.

Regardless of these commitments, however, limited 'donor specialisation or collaboration' has been seen (Kapilashrami & Hanefeld, 2014; Nunnenkamp, Sotirova, & Thiele, 2016). Using data available on AidData for Malawi, Nunnenkamp et al. argue that agencies and projects tend to cluster in particular sectors and geographic areas

that reflect their priorities and agendas rather than the needs of communities (2016). Similarly, Klingebiel et al. show how in Myanmar, EU Member States prioritise their own 'interests, developmental or otherwise' at the expense of EU cooperation and coordination in the country (2017, p. 156). Coordination, they argue, 'is a technical challenge only to a limited extent, as it is also hostage to the political commitment of aid actors' (2017, p. 157). One of the consequences of this fragmentation of aid and development interventions is that it increases the transaction costs for civil servants who are expected to work with each intervention and overburdens already weak health systems (Klingebiel et al., 2017; Pfeiffer, 2003).

This cost of transaction is often a key contributor to the tense relationships between iNGOs and state actors reported across multiple national contexts (Cairney & Kapilashrami, 2014; Kapilashrami & McPake, 2013; Kapilashrami & Hanefeld, 2014; Kapilashrami & O'Brien, 2012; Pfeiffer, 2003). This body of research highlights how the involvement of iNGOs in local health systems places a burden on these local systems as civil servants are expected to take on additional work in line with the agendas of the funding organisations (Cairney & Kapilashrami, 2014; Kapilashrami & McPake, 2013; Kapilashrami & O'Brien, 2012; Pfeiffer, 2003).

Further to the additional work that accompanies programming funded by iNGOs, the role of these organisations in shifting and influencing the political agenda of the state, particularly state health systems, is well documented (Kapilashrami & McPake, 2013; Kapilashrami & O'Brien, 2012; Khan et al., 2016; Storeng et al., 2018). The 'public transcript' of iNGOs, that highlights their commitment to local priorities, capacity building, and partnership, is often undermined by the 'hidden transcript' that requires iNGOs to use their influence and power to shift existing agendas in line with their own (Kapilashrami & McPake, 2013). Providing a suggestion as to why co-ordination among iNGOs may be limited and project proliferation widely seen (Klingebiel et al., 2017; Nunnenkamp et al., 2016). Reflecting on the role of iNGOs in the development of progressive reproductive health policies and programming in Malawi and South Sudan, Storeng et al provide a clear example of the 'hidden transcript' driving iNGOs, noting that:

> Although they emphasise the technical nature of their work, in these interactions (between iNGOs and the state), INGOs are political actors who operate within fields of power relations in which they mobilise both financial power and more subtle forms of power deriving from expertise and claims to moral authority (2018, p. 2)

As such, although some civil servants are able to take advantage of the opportunities that iNGOs provide, particularly as iNGO trainings often provide participants with per diems, and occasionally better paid job opportunities arise (Cairney & Kapilashrami, 2014; Kapilashrami & O'Brien, 2012; Pfeiffer, 2003), the result is ultimately detrimental to local priorities and health systems (Cairney & Kapilashrami, 2014; Hanefeld, Vearey, Lunt, & others, 2017; Kapilashrami & McPake, 2013; Kapilashrami & O'Brien, 2012; Pfeiffer, 2003).

In addition, within iNGOs frustration often develops between 'local' staff, citizens of the country in which the iNGO is working, and 'ex-pats', largely white foreigners from Europe or North America. The latter are by and large treated and paid better, and assumed to have more skills to offer than their local counterparts (Pfeiffer, 2003; Redfield, 2012b). However, as Bell and Coicaud argue: '[t]he story of aid projects in the developing world is littered with blunders that could have been avoided with more detailed local knowledge' (2007, p. 3). These stories, and the involvement of non-state actors with no democratic mandate in service provision and development raises questions about accountability (van Zyl et al., 2018; Younis, 2007). Recent research published by van Zyl, Claeyé, and Flambard (2018) on NGOs and iNGOs in South Africa highlights how iNGOs are 'significantly bigger, older and richer than local NGOs' (2018, p. 14) and feel primarily accountable to donors, including foreign governments - this is reflected in choices not to coordinate interventions, and the consequent oversaturation of projects in particular sectors and geographic areas (Nunnenkamp et al., 2016). Local NGOs, on the other hand, 'are more closely related to the communities that they serve' and tend to feel more accountable to those with whom they work (van Zyl et al., 2018). However, given the amount of funding that iNGOs, specifically GHIs and ODA organisations, have, their ability to shift the agendas of local NGOs, as well as the state, through funding threatens this accountability (Ghanotakis et al., 2009; Kapilashrami & McPake, 2013; Kapilashrami & O'Brien, 2012; Younis, 2007).

Finally, given the timebound nature of the involvement of iNGOs in local contexts, the presence of iNGOs in the health sector has implications for the sustainability of both non-governmental interventions and programmes, which are started and then abandoned as funding comes to an end or another crisis beckons, *and* for state systems, which are overburdened and reoriented (Berlan & Bruno-van Vijfeijken, 2013; Bruno-van Vijfeijken & Schmitz, 2011; Cairney & Kapilashrami, 2014; Kapilashrami & McPake, 2013; Younis, 2007). This literature and the questions that it raises around the

sustainability are discussed in more depth and in relation to the interventions by MSF and the IOM in Musina in de Gruchy and Kapilashrami (2019) [Paper two].

Existing bodies of literature are fairly clear on the role that iNGOs play during times of crisis (for example, Chigudu, 2016; Khan et al., 2016; Redfield, 2010) and shifting local priorities around issues of health (for example, Kapilashrami & McPake, 2013; Kapilashrami, Fustukian, & McPake, 2015; Kapilashrami & Hanefeld, 2014; Kapilashrami & O'Brien, 2012; Younis, 2007). While agenda shifting and setting is a fundamental part of the policy process, what is less clear is the role that iNGOs do, or do not, play in subsequent parts of the policy process (Khan et al., 2018; Smith, 2019). It is this literature that forms the fifth body of literature with which this research engages.

2.5 (Theories of) policy process

2.5.1 Theories of policy process

Initial theories of policy process, by and large, focused on either state institutions as the site of policy development and implementation, networks that developed around lobbying for particular policy choices, or were based on rational choice theory and the idea that policy makers were rational agents (Surel, 2000). By the mid-1980s, however, far more sophisticated theories were emerging 'informed by a recognition of the importance of values, ideas and representations in the study of public policy' (Surel, 2000, p. 495). Referred to as 'cognitive and normative frames', these theories, including Sabatier's Advocacy Coalition Framework (ACF) (Jenkins-Smith et al., 2014) and Hall's notion of paradigm (Hall, 1993), emphasise 'the influence of ideas, general precepts and representations, over and above social evolution and state action…based on the belief that cognitive and normative elements play an important role in how actors understand and explain the world' (Surel, 2000, p. 495).

These more conceptual and complex frameworks have gained traction throughout Europe and North America. However, examples of their use in other contexts are limited. A key example of this is the ACF, which 'models public policy as a conflict between actors competing to translate their beliefs into policy' (Pierce, Peterson, & Hicks, 2017, p. 2): actors form coalitions, or networks, through which they can share resources and expertise and lobby for their policy alternative (Jenkins-Smith et al., 2014). However, while a key framework in the policy process literature, of 224 papers identified as having been published between 1987 and 2013 and having 'used [the ACF] as the primary lens or one of the primary lenses', only six of these studies were

conducted on the African continent (Jenkins-Smith et al., 2014, p. 210). Recent work from Nigeria has argued that the ACF is applicable in developing African countries 'with a stable democratic political system, multiple policy actors, and an availability of technical experts' (Nwalie, 2019, p. 18). However, in general, its application, development, and efficacy has been in the global North (Jenkins-Smith et al., 2014; Nwalie, 2019; Pierce, Peterson, Jones, et al., 2017).

A second theory that has been particularly influential in shaping thinking around policy change has been Kingdon's Multiple Streams Approach (Béland, 2016; Kingdon, 2011). But again, there has been limited application or development of this theory within sub-Saharan African or LMICs in other regions. Kingdon's work importantly brought to the fore the idea of the 'agenda', and subsequently 'agenda setting' – the process of changing or shifting the agenda:

> The *agenda*, as I conceive of it, is the list of subjects or problems to which government officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time. (Kingdon, 2011, p. 3)

For Kingdon, opportunities for 'policy entrepreneurs' – 'advocates for proposals or for the prominence of an idea' (2011, p. 122) - to engage with and shift the agenda happen during time sensitive 'policy windows', when a defined problem, policy alternatives, and political will come together (Béland, 2016; Kingdon, 2011). This process is referred to by Stone as 'issue framing':

> To select some aspects of perceived reality and make them more salient [important or visible] … in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and / or treatment recommendation. (Robert Entman, 1993 in Stone, 2012, pp. 252, 253)

Through this process, the way in which an issue has been framed - the 'ideas' in play – emerge as particularly important for understanding policy change (Béland, 2016, p. 231; Kingdon, 2011, p. 72). As such, Kingdon has largely been credited with the 'ideational turn' seen in studies of policy starting in the 1990s and moving into the 2000s (Béland, 2016, p. 229).

This 'ideational turn' has been seen across studies of policy, and importantly in frameworks, like the '3 I's', that have been used in LMIC contexts (Ashraf, 2016;

Gauvin, 2014; Koh et al., 2017; Palmary & de Gruchy, 2016; Shearer et al., 2016). The '3 I's' - ideas, institutions, and interests - posits that in order to understand a policy process, the institutions involved; the ideas that are contested and that frame the problem and possible solutions; and interests – economic or otherwise – mobilising support ought to be investigated (Gauvin, 2014). An analysis of networks involved in policy making has recently been shown to be a useful addition to the framework (Shearer et al., 2016). Recent research undertaken by the African Centre for Migration & Society (ACMS) and partner institutions in Bangladesh and Singapore indicates that the '3-I's' is useful in a complex, post-colonial context in which research is primarily of an exploratory nature (Palmary et al., 2018). This is due to the fact that it functions primarily as a 'theoretical checklist' rather than a sophisticated theory (Gauvin, 2014). As such, it allows the researcher to simply investigate and describe various elements of the policy process rather than getting caught up in complex conceptual mechanisms (Palmary et al., 2018).

What it lacks, and what more traditional theories like the ACF, for example, are able to provide, are more nuanced and theoretical concepts through which to understand policymaking. An example of this is Devil Shift, which refers to perceptions that one coalition, or network, might have of another, given the other's successes within a subsystem - frequently this manifests as the 'losing' coalition casting the 'winning' coalition as having access to superior resources or behaving unethically (Jenkins-Smith et al., 2014). In general, however, there has been limited engagement with the wholesale application of the ACF (Jenkins-Smith et al., 2014) and other theoretical frameworks, like Kingdon's Multiple Streams Approach (2011), within LMICs.

Furthermore, theories developed in and for LMICs are scarce. One notable exception is Walt and Gilson's, 1994, *Reforming the health sector in developing countries: the central role of policy analysis.* Here the authors argue 'that much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform (at the international, national, and subnational levels), the *processes* contingent on developing and implementing change and the *context* within which policy is developed' (emphasis in original text) (p.354). Actors, processes, and context are, they argue, the three elements that, if sufficiently examined, can explain why and how specific health policy is made, in addition to the policy's content. While the use of this framework has become commonplace in research that analyses the development of health policy in LMICs like South Africa, this kind of policy analysis remains infrequent (see Gilson & Raphaely, 2008 for a review of literature on health policy processes from 1994 to 2007). In addition, although within public health scholarship,

this model has been used over 1 000 times in a variety of contexts, its use outside of public health scholarship is limited (Agyepong & Adjei, 2007; Hanney et al., 2003; Shiffman & Smith, 2007; Trostle et al., 1999). As such, it is not immediately clear whether this framework would, for example, prove particularly useful in an investigation of migration policy.

A final consideration is around the role of non-state actors, which, in a globalised world, needs to be accounted for within our understanding of policy development and change. As Burris et al argue:

> governance cannot be understood as the work only of government. Governance is polycentric, distributed among multiple organizations exercising diverse forms of power. States do not enjoy a monopoly on governance, and themselves are often governed by non-state actors. Governance thus comprises both institutions and procedures formalized in constitutions and laws, and the many institutions – corporations, NGO coalitions – and methods of power – bribery, media campaigns – that are only obscured by equating governance with government (Burris et al., 2007, p. i155)

As highlighted in section 2.4, in an LMIC, such as South Africa, an acknowledgement and understanding of the role that non-state actors play in the development and implementation of policy is imperative. As outlined in that section with regards to agenda setting, as well as in the literature that examines global norms and ideas and their institutionalisation within national contexts (Betts & Orchard, 2014; Palmary & de Gruchy, 2019; Risse et al., 1999; Surjadjaja & Mayhew, 2011), non-state actors play a significant role in shifting national agendas and the norms and ideas to which national policies respond. Few studies however have examined the role of these actors in subsequent stages of the policy process, namely policy development, implementation, and evaluation (Khan et al., 2018). And, as Betts and Orchard argue, while states may be willing to sign and ratify conventions codifying new global norms and ideas:

> Norms – especially people-centred norms such as human rights, development, or humanitarian norms – ultimately only have significance insofar as they translate into practice. (2014, p. 1)

Consequently, while states may be willing to agree to global norms, the development and implementation of national policy and local programmes to translate such norms

into practice is often a process that takes a lot longer and is far more contested and complex (Betts & Orchard, 2014). In the health sector, in which policy has formed a key pillar of research, actors have had more success than in other sectors, largely due to the financial clout behind global actors in this context (Kapilashrami & O'Brien, 2012; Khan et al., 2018), as well as their claims to moral authority (Storeng et al., 2018).

However, it is not only global actors advocating for human rights and access to healthcare for which theories need to account. Global regulatory and standard bearing organisations for produce and trade have 'become increasingly significant mechanisms for governing' (Higgins & Larner, 2010, pp. 1, 2). With regards to agricultural exports, for example, private organisations like Global G.A.P. have been particularly successful in changing the ways in which farmers across the world conduct their business and states regulate standards within the sector (Bain, 2010; Higgins & Larner, 2010). The focus of such organisations on production for the consumer, has undermined farm workers (Bain, 2010). Workers who, in South Africa as in many other contexts, have historically originated from migrant communities and been poorly protected by the state (Arcury & Quandt, 2007; Bail et al., 2012; London, 2003; Visser & Ferrer, 2015; Wisborg et al., 2013).

2.5.2 Developing migration-aware policy

Understanding migration policy, its development, implementation, and inevitable 'failure', has long been a source of interest for researchers (Boswell et al., 2011; Castles, 2004, 2017; Koh et al., 2017; Palmary et al., 2018; Palmary & de Gruchy, 2019; Scholten, 2019). As outlined in the introduction, migration policy is often understood to have 'failed' either migrants themselves when policy is approached from a normative perspective or in its stated aims of curbing migration (Castles, 2004, 2017; Scholten, 2019). Building an argument for why migration policies so often fail to achieve their stated aim(s), Scholten (2019) starts from the premise that migration and diversity (which he understands to be a key concern to which migration policies are responding to) are too complex for single, targeted pieces of policy or legislation to respond to. Rather, he argues, migration should be mainstreamed into policy processes in a similar fashion to gender in acknowledgement of its complexity and relevance for all policy. This is, at first glance, not a dissimilar argument to the one made by those arguing for policies and programming to be migration-aware (Vearey, Modisenyane, et al., 2017; Wickramage & Annunziata, 2018). Mainstreaming in relation to gender has been defined by the UN as:

> the process of assessing the implications for men and women of any planned actions, including legislation, policies or programs/projects, at all levels. It is a process of making women's, as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social sphere, so that women and men benefit equally, and inequality is not perpetuated (Food and Agricultural Organization of the United Nations, 2017)

However, 'mainstreaming' has, especially with regards to gender, often failed to deliver tangible improvements for its intended beneficiaries in both institutions and more broadly across nation states (Mannell, 2012; Rao & Kelleher, 2005; Tolhurst et al., 2012).

This is, by and large, understood to be a consequence of the prioritisation of a single identity marker or social location through mainstreaming (Hankivsky, 2012; Tolhurst et al., 2012, pp. 1827, 1828). Focusing on a single identity marker, like gender or migrant status, facilitates the reduction of all 'women' or 'migrants' to a set of limited experiences or stereotypes in which focus remains on the disadvantages that 'women' face in relation to 'men', or 'migrants' in relation to 'non-migrants'. This is at the expense of understanding the intricacies and experiences of women or migrants themselves, which may be as a result of their gender or migrant status, but may also be as a result of their race, class, or gendered migrant status (Hankivsky, 2012; Tolhurst et al., 2012, pp. 1827, 1828). Reflecting on gender mainstreaming in South Africa, Mannell argues that due to the 'exclusion of race and class from gender mainstreaming' – and therefore the focus on gender exclusively as a single identity marker – the approach has been characterised by an 'ability to gloss over power inequalities' (2012, p. 430), and ultimately achieved very little. As such, gender mainstreaming has become a box ticking exercise rather than a substantive intervention in policy making and implementation. Consequently, there is increasing scholarly opinion that argues that mainstreaming fails the intended targets of its policies (Bürkner, 2012; Hankivsky, 2012; Tolhurst et al., 2012), and there is little to suggest that this would be any different for migration and migrants, or other key populations targeted through such an approach.

In addition to mainstreaming, there are various other approaches for the inclusion of specific issues of concern in government and governance, many of which have emerged in public health (Baum et al., 2014; Mahlangu, Goudge, & Vearey, 2019; Mahlangu, Vearey, Thomas, & Goudge, 2017; Ståhl, 2006; Vearey et al., 2019). One such

approach, which has been key in South Africa's response to HIV (Mahlangu et al., 2017, 2019), has been a multisectoral approach:

> A multisectoral approach (MSA) refers to an approach or a tactic to address a problem from multiple angles that involve various sectors of society involved in governance, namely government, civil society, the private sector, community structures, and individuals (Mahlangu et al., 2019, p. 1)

However, this approach is reliant on the development of effective bureaucratic structures and systems; commitment and buy-in across sectors; as well as, leadership, administration, and constant evaluation (Mahlangu et al., 2019). Consequently, it has often been ineffective in its execution (Mahlangu et al., 2017, 2018).

A second approach is that of Health in All Policies (HiAP). In recognition of the ways in which health is socially determined, 'the core' of this approach' is to examine health determinants that are mainly controlled by policies of sectors other than health' (Baum et al., 2014; quote from Puska, 2007; Ståhl, 2006). This approach requires:

> a whole-of-government approach to health governance, in which health considerations are made as a usual part of the policy making process across all participating areas, allowing governments to address the key determinants of health in a more systematic manner. (Baum et al., 2014, p. i131)

As with the MSA, such an approach requires coordination within and administration from formal state structures, and articulation within state policy (Baum et al., 2014, p. i132). As such, evaluation of such approaches is often complicated and, for the latter, the role that non-governmental actors and stakeholders are able to play in such a bureaucratised approach is not immediately clear (Ståhl, 2006).

However, taking their cue from the successes of HiAP, Vearey et al (2019) argue that a Migration and Health in All Policies (M+HiAP) is required to address the current lack of responses to migration and health in line with global commitments. They argue that this is a key mechanism through which migration-aware and mobility-competent health policy and programming could be developed. Although calls are mounting for migration-aware policies and programming (Vearey, 2014, 2018; Vearey et al., 2019; Vearey, Modisenyane, et al., 2017; Wickramage & Annunziata, 2018) this approach and the mechanisms through which it could be achieved have yet to be tested, and it is likely to fall into many of the same traps as mainstreaming or HiAP.

2.6 Conclusion

In conclusion, while South Africa has a fairly progressive legislative framework with regards to migration, as this literature review has shown, not only are efforts being made by the state to undermine the existent progressive elements, but a pervasive culture of xenophobia limits the rights that non-nationals are able to enjoy in South Africa. Health, and access to healthcare is one of these rights (Landau, 2012; Misago, 2016; Mogekwu, 2005). While South Africa has committed to realising UHC and meeting global health targets, a lack of migration-aware policy and mobility-competent programming is undermining these efforts (Vearey, Modisenyane, et al., 2017). Within this context, it is unsurprising the migrant and mobile communities have limited access to positive social determinants of health and emerge as communities with an undue burden of disease and as communities in crisis at particular points (Gushulak, 2007; Kennedy et al., 2015; Malmusi et al., 2010; Vearey, 2013a, 2014).

Consequently, there are clear moments when humanitarian agencies, UN bodies, and various other non-governmental organisations, both international and local, are able to legitimise intervening in the South African context. However, an improved understanding of such interventions and their implications for governance, service delivery, and the health and wellbeing of communities is needed. As it currently stands, such an understanding has been limited by theories of policy change and process that do not sufficiently take into account the realities of governance and the policy process in the South African, as well as other LMICs, context (Jenkins-Smith et al., 2014; Nwalie, 2019; Pierce, Peterson, Jones, et al., 2017).

As such, acknowledging the lack of locally-relevant policy frameworks, and the limited nature of both research on and responses to migration and health, this PhD seeks to develop a conceptual framework to improve understandings of policy processes around migration and health in South Africa. Given the particular lens that the field of migration and health provides, a case study of the development of policy and programmatic responses to the health and wellbeing of migrant farm workers in Vhembe District, Limpopo will be used.

As such, five objectives have been developed to guide a response to this question:

1. To develop an improved understanding of migration and health within the South African context, specifically of the health and wellbeing of migrant farm workers;

2. To understand how policies on issues of migration and health are framed in South Africa;
3. To investigate the development of policy and programmatic responses to migration and health in South Africa, from agenda setting to implementation, and experiences thereof;
4. To be able to explain, conceptually, why policies are made or left un-made, and in so doing address the limitations of existing frameworks; and
5. To reflect on lessons learnt for future advocacy for better policy processes around issues of migration and health in South Africa.

3 Methodology and Ethics

This research is an exploratory and grounded attempt to contribute towards an improved understanding of the processes around policy and programmatic interventions in South Africa (Lingard et al., 2008). As such, it seeks to answer the question:

> Conceptually, how can we understand policy processes within various spheres of governance in a way that accounts for ideas, influence, and evidence, without neglecting the ways in which different spheres of governance interact, aggravate, and mediate the policy process for each other?

Consequently, the various methods and approaches taken have been used on the understanding that they are ideally placed to explore the research objectives and ultimately respond to the research question. Several qualitative methods were used, namely an analysis of published literature on the policy process and existing frameworks, an analysis of grey literature, conducting and analysing key informant interviews, and conducting and analysing participant and non-participant observation. Each of these methods is discussed in more detail below.

While this project was started in 2016, the research was primarily undertaken in 2017. Much of the research with the Department of Health (DoH) in Musina was conducted between May and July 2017, as was the research that took place on the two farms within the Musina Local Municipality. However, some participant observation was conducted as late as 2019. Given the central role that international organisations played in this research, interviews were also conducted with current and former employees of these organisations in Musina, as well as in Cape Town, Pretoria, and Geneva (via Skype). Representatives from government departments and agricultural organisations were interviewed in Pretoria, Polokwane (the Provincial capital of Limpopo), and Makhado (a town in Limpopo).

In keeping with a grounded theory approach, the research process has been iterative, as each stage of the research and data collection informed subsequent or simultaneous processes of data collection (Lingard et al., 2008).

3.4 Justification of methods

This research has both empirical and conceptual objectives. As such, grey literature, key informant interviews, participant, and non-participant observation have been used to generate empirical data and inform an empirical understanding of what happened and is happening in Musina. This data has then been used to inform a conceptual understanding of this process and respond to my research question.

Due to the exploratory nature of the research, multiple methods and sources of information are used in this research to capture the development, implementation, and sustainability of the interventions, as well as perceptions and insights into these processes. The remainder of this section articulates the use of these various methods.

3.4.1 Identification and review of published literature and existing frameworks

The point of departure for this research has been the identification and review of published literature around questions of policy making in South Africa, specifically in relation to policies around issues of migration and health. The objective here is to understand which policy frameworks are being used to explain policy making in South Africa and what the limitations of these frameworks have been to date. The Advocacy Coalition Framework (ACF) (Jenkins-Smith et al., 2014; Sabatier, 1991), Kingdon's Multiple Streams Approach (Béland, 2016; Kingdon, 2001, 2011), Walt and Gilson's model for analysis, which centres content, context, process, and actors (Walt & Gilson, 1994), and the 3 I's (Gauvin, 2014; Shearer et al., 2016) have all been analysed through a reading of the theory or framework in conjunction with the analysis of the empirical data collected through this research. Other theories and approaches, like the Narrative Policy Framework, have been engaged with on a more ad hoc basis (McBeth et al., 2014). In addition, work that has proposed additional approaches to policy making, especially with regards to migration, like migration- and health- in all policies (M&HiAP), has also been reviewed (Scholten, 2019; Vearey et al., 2019; Vearey, Modisenyane, et al., 2017; Wickramage & Annunziata, 2018).

A discussion of this review can be found in the Literature Review, section 2.5.

3.4.2 Grey literature

Two bodies of grey literature have been analysed as part of this research. The first are global, regional, and national policies, instruments, and commitments regarding migration and health. This analysis has informed the discussion undertaken in the

literature review. Table 5, building on Vearey (2018), merges tables 2, 3, and 4, and presents a list of the policy documents directly consulted and analysed.

Table 5: Overview of policy documents

	Migration policy Policies that specifically address 'migration', rather than specific kinds of migrants, e.g. refugees or labour migrants	**Health policy**	**Migration & health policy** Policies that specifically address migration and health
Global	Global Compact on Safe, Orderly and Regular Migration (2018) (GCM)	Global Compact on Universal Health Coverage (UHC) (2018)	Promoting the health of refugees and migrants: Global action plan (GAP), 2019 – 2023 (2019)
	Global Compact on Refugees (2018)	Sustainable Development Goals, Goal 3 (Agenda 2030) (2015)	World Health Assembly Resolution WHA 70.15 Promoting Health of Refugees and Migrants (2017)
	New York Declaration for Refugees and Migrants (2016)	UNAIDS 90:90:90 (2014)	World Health Assembly Resolution WHA 61.17 on the Health of Migrants (2008)
Regional African Union (AU) and Southern African Development Community (SADC)	AU Migration Policy Framework for Africa and Plan of Action (2018 - 2030) (2018)	SADC HIV and AIDS strategic framework (2010 - 2015)	SADC Declaration for Tuberculosis in the Mining Sector (2012)
		Protocol on Health (1999)	Policy Framework for Population Mobility and Communicable Diseases in the SADC Region (2009, Draft)
National South Africa	White Paper on International Migration (2017)	Policy Framework and Strategy for Ward-Based Primary Healthcare Outreach Teams (2018/19 - 2034/24) (2018)	
	Immigration Act (2002)	National Health Insurance White Paper (2015, 2017)	
		National Strategic Plan (NSP) on HIV, STIs and TB (2017 - 2022) (2017)	
		Community Health Workers Policy Framework (2004)	
		National Health Act (2003)	

The second body of grey literature that has been analysed pertains to the creation and implementation of policy and programmes on the farms included in this study and includes, for example, policy directives, memos, and minutes from meetings. There

are two reasons that this body of grey literature is deemed an important source of data for this study. The first is that meeting minutes and annual reports are important sources of information needed to create 'a sufficiently rich, detailed and practical understanding of complex interventions' (Adams et al., 2017, p. 446), as they detail projects, discussions, and concerns, at specific times during a project. The second is to mitigate against the bias of key informants and memory loss, as the perspectives of informants 'are necessarily limited, selective, and biased' (Patton, 2002, p. 321). For both of these reasons, grey literature has proven invaluable as it, for example, provides information on the exact number of Community Health Workers (CHWs) that were working in the area at Médecins Sans Frontières's (MSF) exit, their nationalities and sex, when key informants are far vaguer about these particularities.

The use of this data has, however, been limited to what I have been able to access. Several individuals have been particularly helpful and sent me reports, meeting minutes, and memos that they still have. But I have been reliant on them, documents that the International Organization for Migration (IOM) in Musina deemed sufficiently important to keep and were willing to share, and information that individuals and the organisations that they worked for have considered appropriate to publish as blogs or opinion pieces. The IOM offices in Musina emerged as a particularly rich source of grey literature as they were still operational in Musina at the time that I undertook fieldwork and have kept a wide array of files and documentation from their ten years in the area. In total, I analysed 76 documents relating to the projects (see Table 6 for details).

Table 6: Grey literature on Musina programmes

Project/organisation to which grey literature was related	**Number of documents**	**Where and how documents were located**
Ripfumelo[28] (Change Agent project) IOM	21	IOM files, Ripfumelo project evaluation requested from IOM International
VDMHF[29] IOM	35	IOM files, email listserv for the VDMHF

[28] The Ripfumelo Project, which had two iterations Ripfumelo I (2009 – 2011) and Ripfumelo II (2012 – 2015), was part of the IOM's Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The aim of the project was to 'provide support to the South African government in its response to addressing migration health concerns in the context of HIV, TB and other communicable diseases' (Ripfumelo II 2012 – 2015 Project description) and was implemented across several districts in four South African provinces, including Vhembe. The Change Agent programme was a cornerstone of the IOM's Ripfumelo programming in Vhembe.

[29] The Vhembe District Migrant Health Forum. Discussed in more detail in section 3.1.4 *Participant Observation.*

Musina Model of Care MSF	20	IOM files, email correspondence with MSF (former) employees, online
Total	**76**	

3.4.3 Key informant interviews

Given the exploratory nature of this research, key informant interviews form a cornerstone of this research and have been able to provide data that is both descriptive and explanatory (Hesse-Biber & Leavy, 2011, pp. 96–98). A semi-structured interview guide was developed for each of the interviews. Each guide was designed to establish 'the concepts one needs to measure to answer the research question' (Beamer, 2002, p. 87) to ensure that the data from the interview shows whether the informant responded to a concept, for example migration, consistently, so that alternative explanations for a response are eliminated (p. 88). Key informant interviews were used to interrogate and explore: what ideas have an impact on policy decisions; how influential the various spheres of governance are in the making of these decisions; who the stakeholders involved in these processes were and are; and whether existing policy frameworks make sense in the South African context. Furthermore, while some interview guides were used for more than one interview – for example, the interview guides for Change Agents and farm workers – I made a conscious effort to ensure that guides ask interviewee-specific questions. For an example, see Appendix C.

Key informants broadly fall into three groups: (1) those who have insights into the broader context of the agricultural sector and the health and wellbeing of farm workers; (2) those who have been involved in the development and implementation of the specific policy and programmatic interventions in Musina; and (3) farm workers, the intended beneficiaries of these interventions.

Prior to beginning this project, I had been part of a research project that had explored the profiles and experiences of primary healthcare facility users in Limpopo and Gauteng, including in Musina (Vearey et al., 2016). Due to insights from this work, as well as existing knowledge that the ACMS had of the area and initial scoping work that was done in 2015, it was clear who some of the key informants would be at the outset of this project. However, the iterative design of the project allowed for snowball sampling, the identification of key informants as the research progressed (Lingard et al., 2008). Beamer (2002) highlights the potential for snowball sampling to result in bias and error should research participants exclusively refer the researcher to others who would confirm their perspective. To avoid this, participants were asked both to recommend informants generally, as well as specific questions around recommending

participants in the DoH, for example. Within the second group of informants – those who had been involved in the projects in Musina – it was fairly easy to reach some consensus as to who had been involved and to reach out to as many of them as possible. For the first group this was more of a challenge as the potential number of individuals that I could interview was much larger. As such, I tried to be purposive and strategic in understanding who might be able to provide a perspective and information that would be particularly relevant to (a) understanding the agricultural sector in South Africa more generally, as well as in Musina specifically; (b) understanding the ways in which the DoH is structured and works in the provision of healthcare in districts and sub-districts; and (c) understanding the role of international organisations within this context.

In total, 79 interviews were conducted (see Table 7 for details). Nine of the interviews were conducted as group interviews - four with farm workers, one with service providers, two with civil servants, one with the South African Local Government Association (SALGA) and one with an agricultural organisation. This was primarily because the original research participant contacted felt that their colleague(s) would have helpful insights. As such, the number of interviews, rather than the number of interviewees, has been recorded.

Hesse-Biber and Leavy claim that semi-structured interviews allow for data collection and analysis to happen simultaneously (2011, p. 123). This was something which resonated with my experiences in conducting this research as each interview allowed more insight into the development and implementation of the interventions in Musina and often resulted in the development of new questions for subsequent interviews. Given this benefit, I tried to make notes and transcribe each interview as it was conducted. This was possible in some cases, but at other times this was not possible. One key example was when interviews were being done with farm workers – most of which were in ChiShona.

Interviews that were conducted in ChiShona, a language widely spoken in Zimbabwe, were conducted by two research assistants - Learnmore Mvundura and Edward Govere – both MA students at the ACMS at the time and speakers of ChiShona. The audio recordings of these interviews, which do not include any identifying information, were transcribed and then translated into English. The transcriptions are in both ChiShona and English, so any questions around a particular translation can be double-checked. Once the translation and transcription were completed, I analysed these transcripts together.

Table 7: Key informant interviews

	Interviews conducted with	Number of interviews conducted
Agricultural sector organisations	3 men	5
	1 woman	
	1 group (mixed)	
Change agents	7 men	11
	2 women	
	2 groups (mixed)	
Community Health Workers (CHWs)	3 women	3
Farm management	2 men	5
	1 woman	
	1 group (mixed) interviewed twice	
Farm workers	13 men	32
	18 women	
	1 group (all women)	
Non-governmental organisations (local and international)	5 men	11
	6 women	
Mobile clinic staff	3 women	4
	1 group (mixed)	
Other	2 women	3
	1 group (all men)	
Total		**79**

3.4.4 Participant observation

Since starting this project in 2016, I have been involved in various and varied fora and events as a researcher in the field of migration and health. My involvement in these spaces has contributed to an improved understanding of the field and the various stakeholders engaged with migration and health. An overview of all of these events and spaces is beyond the scope of this section. However, the details of key examples of participant observation that I undertook between 2016 and 2018 can be found in *Table 8*. I attended all of these events as a researcher from the ACMS. Several participants became familiar with me as a PhD student within these spaces, which often served as an opportunity to identify potential key informants or meet up with individuals that I had already interviewed.

Of primary significance was my participation in the Vhembe District Migrant Health Forum (VDMHF). Migrant health forums have emerged as a local level response to concerns around migration and health in various parts of South Africa. Established in Vhembe and Johannesburg, as well as other districts in Limpopo and Mpumalanga, they provide a space for stakeholders to monitor, connect, and develop responses to

issues of migration and health (Vearey, Thomson, Sommers, & Sprague, 2017). I attended two meetings of the VDMHF in 2017 (one on the 8 February, and the other on the 28 July) and have been on the forum mailing list since 2015. Meetings are intended to happen every three months, but their scheduling is sporadic and subject to last minute changes, so it has not been possible to attend more of these meetings.

Table 8: Key examples of participant observation

Date	Event	Venue
1 August 2019	Public symposium and the South African launch of the Lancet Commission Report on Migration and Health	Johannesburg, Gauteng
20 July 2018	Ehlanzeni Migrant Health Forum	Nelspruit, Mpumalanga
28 July 2018	VDMHF	Musina, Limpopo
17 and 18 March 2017	Department of Home Affairs (DHA) conference on International Migration	Johannesburg, Gauteng
8 February 2017	VDMHF	Musina, Limpopo
22 and 23 November 2016	IOM organised second National Consultation on Migration and Health	Johannesburg, Gauteng
14 October 2016	Public engagement on the National health Insurance	Johannesburg, Gauteng
19 August 2016	Joburg Migrant Health Forum and maHp policy dialogue on Migration, mobility, and the UNAIDS 90: 90: 90 targets	Johannesburg, Gauteng
26 July 2016	Dialogue on the portability of social security benefits in the South African Development Community (SADC) region	Johannesburg, Gauteng

Ritchie and Lewis describe participant observation as the process through which

> the researcher joins the constituent study population or its organisational or community setting to record actions, interactions or events that occur. This not only allows phenomena to be studied as they arise, but also offers the researcher the opportunity to gain additional insights through experiencing the phenomena for themselves. This method is integral to anthropological and ethnographic research because it provides 'direct experiential and observational access to the insiders' world of meaning' (Jorgenson, 1989:15). (2003, p. 35)

I found this to be a particularly informative and interesting way through which to interact with research participants, some of whom I had interviewed or would then interview and develop a rapport with. Inter- and intra- organisational dynamics become more apparent in these spaces. One clear example is around the IOM who are simultaneously regarded as 'experts' on migration and health and deferred to by state officials around definitions and 'knowledge' around these issues, but remain reliant on these same state officials to attend and chair the VDMHF and to be interested in their 'expertise', something which is not always the case.

3.4.5 Non-participant observation

Observation of the mobile clinic programme was undertaken throughout the research. Given the nature of work on the mobile clinics, conducting in-depth interviews with services providers in the programme is difficult and obstructs their work. Observation, on the other hand,

> allows events, actions and experiences and so on, to be 'seen' through the eyes of the researcher, often without any construction on the part of those involved. It is a particularly useful approach when a study is concerned with investigating a 'process' involving several players, where an understanding of non-verbal communications are likely to be important or where the behavioural consequences of events form a focal point of study. (Ritchie & Lewis, 2003, p. 35)

Throughout my time in Musina, I was able to spend time at the mobile clinic headquarters in the town as the staff prepared to go out to the farms and held weekly meetings. On several occasions, I also followed the mobile clinic out to the two farms on which I was conducting research and observed its reception.

In addition, on four days in June 2017, one of my research assistants was able to travel with one of the mobile units as it visited farms in the area. Observation and informal conversations recorded as field notes provided rich data on the day-to-day concerns of the mobile clinic staff and the constraints under which they operate. This time was used as an opportunity to engage with questions around the continuity of the programme since the departure of MSF, and the ways in which the mobile clinic programme worked, and continues to work, in conjunction with the CHW and Change Agent programmes, and the VDMHF. No treatment or care itself was observed.

Finally, in July 2019 I was able to observe a Chatham House Rule roundtable on *Migration and health in South Africa and the region: Addressing access to care and inclusion in Universal Health Coverage (UHC)*. This event brought together academics, state bureaucrats and policy makers - including representatives from key government departments, and civil society to discuss the limitations of the proposed National Health Insurance (NHI) with regards to migration and migrants, and how the NHI as currently envisaged would undermine South Africa's ability to realise UHC. Observation of this event, the various ways in which stakeholders interacted and the use of rhetoric and language by stakeholders, has informed my understanding of the policy making process, specifically in relation to stakeholder interaction and the importance of ideas.

3.5 Analysis of data

Although the analysis of data collected through each of the above methods has been approached somewhat differently, in general analysis of the data was thematic. 74 codes were identified through an examination of the data and explored in relation to each other as themes (Fereday & Muir-Cochrane, 2006).

Interview data has been coded using Dedoose 8.2.14, software that allows for the filing, coding, and analysis of qualitative data with some ease. Grey literature and fieldnotes have not been analysed using Dedoose, as fieldnotes were recorded by hand and much of the grey literature is either in the form of a hard copy or a scanned copy with print that the software could not identify. However, the same analytical approach has been applied across the data.

Given the fragmentation of knowledge around policy processes, specifically policy processes around issues of migration and health, analysis has been inductive. In other words, analysis of the transcripts and documents has led to the identification of concepts and categories of interest, rather than preconceived concepts or an existing conceptual frame dictating the analysis of the data (Elo & Kyngäs, 2008, p. 109). As such, codes have been identified as the data has been analysed. Consequently, pieces of data that were analysed at the beginning of the process have been reanalysed towards the end to ensure that codes identified later in the analysis have been applied uniformly. The codes themselves have been analysed and given rise to the four themes around which the findings have been framed.

3.6 Ethical considerations

Ethical clearance was granted for this project from the Wits Human Research Ethics Committee (Non-Medical) (HREC), protocol number H16/08/10 (Appendix D).

3.6.1 Maintaining confidentiality and anonymity

Potential participants were invited to participate in the research and provided with an information sheet that outlined the project and its aims (Appendix A). If the individual consented to being interviewed, they were asked whether they had any questions and to sign an informed consent form (Appendix B). The informed consent form includes a separate question, requiring a signature, which asks whether the participant consents to an audio recording being made of the interview. While I explained that confidentiality may not be possible for key informants, particularly those in visible and unique positions and those participating in group interviews, I have anonymised the data to the best of my ability.

3.6.2 Data storage

As per approval of the HREC, all data, including the audio recordings and transcripts, is kept in my private, password protected Dropbox and on a private hard drive. There is some concern that online storage of data is unsafe, as a Dropbox account can be hacked (Gibson & Gross, 2013). However, given that confidentiality has not been guaranteed to key informants, I feel that this is an appropriate method of data storage. Additionally, interview transcripts are kept on Dedoose, which is password protected.

3.6.3 Reflexivity & positionality

Within all research, reflexivity and positionality are important. Described by Robertson as 'the capacity of any system of signification, including a human being … to turn back upon or to mirror itself' (2002, p.785), reflexivity creates the space for the researcher to examine, among other things, themselves within the research, their expectations, their position, and the effect they have on the research itself. While Robertson cautions against getting too caught up in examining one's role as researcher, I do think that it is important to have the space to think through and reflect on my experiences and position and the ways that this affected and continues to affect the research.

My position as a white, middle class woman means that I am highly visible when I visit farms or government buildings, and often leads to farm workers directing questions or comments towards me about what I can do for them. While I make it clear

prior to any interactions that I am a researcher and have no power to direct change on the farm or within South Africa more generally, requests were and, on occasion, continue to be made of me.

Bearing in mind that this research will do little – if anything - to improve the lives of farm workers, I decided, in line with standards set by previous work at the ACMS, to ensure that both research assistants and I had juice boxes and snacks on us to offer participants as we interviewed them (Vearey, 2013b). However, as one of the research assistants notes in his fieldnotes

> People also ended up wanting to participate in the interviews because they wanted the freebies that were on offer. Also, the giving out of freebies after interviews to participants as a sign of appreciation proved a challenge especially in the presence of other people who also wanted freebies. (LM fieldnotes 22.06.2017)

This reflects findings by others about the realities of offering a food token to research participants (see, for example Molyneux et al., 2009). Molyneux et al. reflect on implications of this for longitudinal research, arguing that although food parcels introduced new social dynamics to the research, the lived realities of research participants necessitated some kind of compensation for the time taken to participate in the research. In this case, research was not longitudinal, so longer-term expectations were not created. However, in recognition of the fact that food tokens could influence the giving of consent, a decision was made to make the juice boxes and snacks more openly available, especially to children, around the compound.

3.7 Limitations

Limitations in accessibility to farms and civil servants are two of the primary limitations of this project. I had hoped to conduct research on a variety of farms, including those that are not visited by the mobile clinic and those run by black farmers. However, many farmers that I contacted did not respond to my emails or text messages. While research that I have been able to do on the two farms yielded much data, both farms are owned by white farmers who reported to have had fairly positive experiences of the mobile clinic, as well as being home to CHWs and Change Agents.

I had also hoped to be able to interview more civil servants. However, many civil servants, specifically within Vhembe District, did not respond to emails or calls. Many

of the civil servants that I did manage to interview are invested in the interventions in Musina, and ensuring their longevity, and as such are very willing to be interviewed. Of most frustration are civil servants within Vhembe District, within which Musina Municipality sits. Much of the responsibility for the running of the mobile clinic programme and the VDMHF falls on the District. However, emails, phone calls, and trips to Thohoyandou (the District capital) (a six-hour trip from Johannesburg and a two-hour trip from Musina) yielded little except frustration on my part. While I do think that the lack of perspective from the District limits the research, of small consolation is the fact that according to both Provincial and Sub-district civil servants, the involvement of the District in these programmes is minimal. In fact, my frustration mirrors their frustration at the disinterest of the District in supporting the Sub-district and ensuring that the programmes implemented by MSF and the IOM, including the VDMHF, continue.

Given the distances between the various geographic points at which this research was conducted - Musina is 520km from Johannesburg, about a six-hour drive, and the farms are between 45 to 60 minutes from the town centre; the poor quality and dangerous nature of the roads up to and around Musina and Thohoyandou; and the limited cell phone reception in parts of Vhembe, I endeavoured to contact research participants and set up meetings and interviews prior to arrival so as to limit unnecessary time and travel. Unfortunately, this was sometimes difficult as potential participants often did not want to commit ahead of time and preferred that I 'popped in' to see if they were available.

In addition, due to the distance between Johannesburg and Musina, this research was fairly expensive to conduct; petrol, accommodation, and food were all necessary expenses for my time in Limpopo. Unfortunately, while I had funding to cover these costs, the practicalities of accessing the money through the university's systems was one of the biggest causes of stress during fieldwork. Delays in this system meant that at various points I had to use my own money, borrow money from family, and at one stage even delay a trip by a day. While I am fortunate enough to be in a position to do so, this caused unnecessary stress and directed attention away from the research.

Finally, working with and managing research assistants was not something in which I had any experience. Given the dearth of public transport in the area all three of us were solely reliant on my car, which only I could drive. In addition, given that both farms are about an hour's drive from Musina, it was difficult to drop the research assistants off and then return to Musina. However, at the same time, while they

worked, I did not want to remain too present and overshadow or frustrate their attempts at research - I am very aware of my presence as a white woman with a car in the compound. I did conduct a couple of the preliminary interviews with farm workers, specifically Change Agents and CHWs. However, I hope that the use of black, male, Zimbabwean research assistants, apart from overcoming the language barrier, increased the number of farm workers interested in and willing to be interviewed, and distanced the project from any expectations of support or intervention. Fortunately, both farms have central administration offices where I could sit. This lent itself both to conversations with farm management and the opportunity to conduct non-participant observation and observe the ways in which different people interact and the farms are managed.

3.8 Structure of the remaining chapters

The next four chapters of this dissertation present the four papers in which the findings from this research are presented and discussed. Four key findings emerged through this research:

(1) that the Social Determinants of Health (SDH) for migrant farm workers are vast and that access to determinants that could positively affect the health of this community and these individuals is poor;
(2) that responses by the state to the health and wellbeing of migrants are usually crisis-bound and targeted;
(3) that non-state interventions are time-bound, localised, and not politically supported by the South African state; and
(4) that community-based healthcare workers can form part of a migration-aware response to health.

Prior to each paper, an overview is provided that highlights the key themes discussed in the paper, and how this relates to the other three papers, as well as the broader dissertation.

4 Paper one – 'Left behind': Why implementing migration-aware responses to HIV for migrant farm workers is a priority for South Africa

This paper, co-authored with Jo Vearey, is in press with *the African Journal of AIDS Research*. In this paper, the first key finding - that the Social Determinants of Health (SDH) for migrant farm workers are vast and that access to determinants that could positively affect the health of this community and these individuals is poor – is explored. Situated within the literature explored in *sections 2.1 – 2.3*, this paper explores the complexities of the political, social, and legislative context within which migrant farm workers in Musina find themselves. This context, within which they struggle to access positive determinants of health, is unpacked and used to build an argument for the necessity of migration-aware and mobility-competent policies and programming in South Africa.

This paper uses data collected through an analysis of legislative and policy documents, qualitative interviews, as well as participant and non-participant observation. Building on this data, the SDH approach is used to lay out the various structural and intermediary determinants that limit the access that migrant farm workers have to the healthcare system, as a determinant of health and as a system constrained by the broader political and social context within South Africa. Global markets and standards, tensions between the state and the agricultural sector, the management of migration into South Africa, and the lack of social value that is given to the health of migrant farm workers are investigated as key structural determinants of the context within which migrant workers are 'left behind'. As are the material circumstances within which they live and work and their limited access to positive psychosocial and behavioural determinants. The interventions by Médecins Sans Frontières (MSF) and the International Organization for Migration (IOM) are used to highlight the various ways in which the healthcare system itself is a determinant of health that this community struggles to access. In addition, while all of the papers reflect on the necessity of migration-aware and mobility-competent health policy and programming, this paper draws a clear link between South Africa's efforts to meet its global commitments to Universal Health Coverage (UHC) and UNAIDS 90:90:90 targets, and the subsequent need to ensure that this key population is not 'left behind' in order to do so. Against this context, a clear argument for the necessity of migration-aware and mobility-competent policies and programming is built.

This paper lays the foundations on which the proceeding three papers are built. Paper two (de Gruchy & Kapilashrami, 2019) uses MSF's intervention, the Musina Model of Care, as a case study through which to build an understanding of the kinds of responses to migration and health that are seen in the absence of migration-aware policies and programming. Paper three (de Gruchy, 2019) argues that community-based healthcare workers could form part of migration-aware and mobility-competent programming, but the reluctance of the state to sustain these cadre of workers undermines this potential. Finally, paper four (de Gruchy, submitted) uses the context described in this paper, specifically the realities around governance in the agricultural sector, to build a conceptual understanding of policy processes through the empirical understanding of responses to migration and health explored across papers one, two, and three.

African Journal of AIDS Research 2020, 19(1): x–x
This is the final version of the article that is published ahead of the print and online issue

Copyright © NISC (Pty) Ltd
AJAR
ISSN 1608-5906 EISSN 1727-9445
https://doi.org/10.2989/16085906.2019.1698624

Research Article

"Left behind": why implementing migration-aware responses to HIV for migrant farm workers is a priority for South Africa

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Like many other countries, South Africa (SA) has committed to the Sustainable Development Goals (SDGs), that aim to "leave no-one behind", in efforts towards Universal Health Coverage (UHC), and meeting the UNAIDS 90–90–90 targets through the implementation of Universal Test and Treat (UTT) interventions. SA is associated with high levels of international and internal migration that, in certain contexts, are known to (1) increase the risk of acquiring HIV and (2) present challenges to HIV treatment access and continuity. Despite this, migration and mobility are not adequately considered in responses to HIV. As SA rolls out UTT programmes and Antiretroviral Treatment as Prevention (TasP) interventions – including pre-exposure prophylaxis (PreP) – there is an urgent need to ensure that these are migration-aware and mobility-competent. In SA, a key population who experience a disproportionate burden of HIV are international migrant farm workers living and working on commercial farms along the border with Zimbabwe. In this paper a social determinants of health approach is applied to explore the context within which this population struggles to access positive determinants of health, including the public healthcare system, and the implications of this for HIV programming. It is argued that unless policies and programming become migration-aware and mobility-competent, UTT and TasP interventions will struggle to address the high burden of HIV among this population and, as a result, progress towards global health targets will be limited.

Keywords: social determinants of health, governance, migration and health, universal health coverage, sustainable development goals

Introduction

Migration and HIV in South Africa

As South Africa and other Southern African Development Community (SADC) member states[1] commit to an increasing number of global health targets, there is increasing recognition that certain population groups are "left behind", particularly in relation to HIV (Scheibe, Brown, Duby, & Bekker, 2011; Stuart & Samman, 2017; Duby, Nkosi, Scheibe, Brown, & Bekker, 2018). Such groups, or "key populations" to use the UNAIDS definition, have historically included "men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people", who tend also to be associated with higher levels of migration than the general population (WHO, 2017, p. 1). Some specialised interventions exist that are designed to meet the specific HIV needs of key population groups in South Africa (for example, see Brown, Duby, & van Dyk, 2013; Carney, Williams, & Parry, 2016; Scheibe, Richter, & Vearey, 2016; Duby, Fong-Jaen, Nkosi, Brown, & Scheibe, 2019; Eakle et al., 2019). A recent example is the Médecins sans Frontières' (MSF) Bending the Curves project in Eshowe, which has just met and exceeded the UNAIDS 90–90–90 targets, reporting 90–94–95 in the community (Médecins Sans Frontières, 2019a, 2019b). However, responses remain limited (Duby et al., 2018) and – where they do exist – do not adequately engage with migration and mobility (Tanser, Bärnighausen, Vandormael, & Dobra, 2015; Camlin, Cassels, & Seeley, 2018). In South Africa, a country associated with high levels of both HIV and migration, those who are on the move are increasingly recognised as a key population, and calls are being made to ensure that migration and mobility are considered in the development of HIV programmes (Scheibe et al., 2011; Cassels, Jenness, & Khanna, 2014; Tanser et al., 2015; Camlin et al., 2018; Vearey, 2018).

A complex relationship between migration and HIV exists in the SADC region (Vearey, 2018). Migration has historically been associated with HIV prevalence at a population level (discussed further below in "Migrant workers and HIV"). Although this is no longer the case today (Coffee, Lurie, & Garnett, 2007; Kenyon, Colebunders, Voeten, & Lurie, 2014), persistent challenges in ensuring access to and continuity of HIV treatment and care mean that being a migrant remains associated with an increased risk of acquiring HIV (Lurie et al., 2003; Camlin et al., 2010, 2018; Lurie & Williams, 2014; Tanser et al., 2015). This has negative implications for efforts towards Universal HIV Testing and Treatment (UTT) and consequently endangers efforts to achieve global targets. Key challenges include:

> … increased risk of antiretroviral therapy (ART) nonadherence, lost to follow-up, deterioration in CD4 count, HIV-related death, development of drug resistance and general noncontinuity of HIV care. (Tanser et al., 2015, p. 430)

As a result, it is increasingly recognised that health policies and programming need to be migration-aware and mobility-competent in order for key HIV interventions, including UTT and Anti-retroviral Treatment as Prevention (TasP), to reach and affect migrant populations (Cassels et al., 2014; Tanser et al., 2015; Camlin et al., 2018; Vearey, 2012, 2018). However, efforts to develop such responses are lacking at both the national level in South Africa and at the regional level in SADC (Cassels et al., 2014; Camlin et al., 2018; Cassels, Camlin, & Seeley, 2018; Vearey, 2018). This has negative implications for progress towards global health targets including Universal Health Coverage (UHC), as part of the Sustainable Development Goals (SDGs), and UNAID's 90–90–90 (Camlin et al., 2018; Vearey, 2018). In spite of South Africa's commitment to these targets, specifically the UNAIDS 90–90–90 targets, through UTT and TasP, including PreP:

> … the sobering reality [is] that what has been achieved to date has been achieved in easier to reach populations … inadequate attention has been paid to population mobility, a major force that challenges the HIV care cascade and threatens the promise of "treatment as prevention" particularly in high HIV prevalence, resource-limited regions. (Camlin et al., 2018, p. 1)

Migrant workers and HIV

South Africa has long relied on migrant labour from the SADC region in key sectors, including commercial agriculture and the mining industry (Budlender, 2014). Historically, patterns of labour mobility and migration, specifically as part of the highly structured migrant labour system that existed in South Africa during Apartheid, have been associated with the spread of sexually transmitted infections (STIs), including syphilis and HIV, and with the high prevalence of tuberculosis (TB) among migrant workers (Kark, 2003; Hargrove, 2008; Vearey, 2012). As early as 1949, it was recognised that "the pattern of society" created by the migrant labour system in Southern Africa did "not allow for the healthy development of the individual" (Kark, 2003). While migration is no longer associated with the spread of syphilis, or HIV at a population level, migration and mobility remain a determinant of health. Migrant workers experience a disproportionately higher risk of acquiring HIV than the general population, and face challenges in accessing HIV prevention, testing, treatment and care (Camlin et al., 2018). Unfortunately, this has garnered limited attention from the state. Specific concerns around, for example, the health of (former) miners who migrated to worked in South African gold mines, have gained traction (Baleta, 2012). However, similar attention has not been paid to migrant workers in other sectors and industries, including the agricultural sector, or to the importance of migration as a determinant of health more generally in the Southern African context (Vearey, 2014; Vearey, Modisenyane, & Hunter-Adams, 2017).

Globally, migrant farm workers are recognised as a population that struggles to access positive determinants of health, with implications for their risk of exposure to HIV (Arcury & Quandt, 2007; Rye & Andrzejewska, 2010; Abubakar et al., 2018). This is no different in the South African context, where migrant farm workers bear a disproportionate burden of HIV (Colvin, 2010). A 2010 study conducted by the International Organization for Migration (IOM) found that HIV prevalence among migrant farm workers along the South African border with Zimbabwe was 28.1%, almost double that of Vhembe District (14.7%) within which the farms are located:

> The prevalence of HIV among the farm workers in this study is the highest published level among an employed population in the region of which the authors are aware. Most other studies of employed populations in the region (e.g. Colvin et al., 2007b) reported that employed people tend to have a lower prevalence than the general population. The opposite is true on these farms, as the workers are much more likely to be HIV positive, compared with those living in the wider districts – sometimes even twice as likely to be HIV positive. (Colvin, 2010, p. 9)

However, while migrant and mobile populations – including migrant workers – are at an increased risk of acquiring HIV, they remain side-lined in current HIV prevention programmes (Camlin et al., 2018). This is in spite of the fact that in South Africa non-nationals have the right to access free primary healthcare, including HIV and TB testing and treatment, and to be means tested for access to higher levels of care on a par with South African citizens (Johannesburg Migrant Health Forum, 2016). This right, however, rarely translates into available, acceptable and affordable access to health care for international migrants – including in relation to HIV programming (Médecins Sans Frontières, 2009; Crush & Tawodzera, 2014; Makandwa & Vearey, 2017; Vearey et al., 2017; Vearey, 2018). With a few notable exceptions, for example the SADC and North Star Alliance wellness centres (North Star Alliance, 2011; Penfold, 2017) and North Star Alliance Mesedi app (North Star Alliance, 2016), responses to address the HIV needs of migrant workers in South and Southern Africa are limited (International Organization for Migration, 2010).

In this article, we use the Social Determinants of Health (SDH) framework (Commission on Social Determinants of Health [CSDH], 2008) to explore the ways in which migrant farm workers are rendered vulnerable to HIV in the Musina sub-district of South Africa, the northern most part of Vhembe District that borders Zimbabwe. We draw on original, qualitative research conducted on two commercial farms in the area. Using interventions by MSF and the IOM that sought to improve the access that these, primarily Zimbabwean, migrant farm workers had to healthcare as an entry point, we highlight the opportunities and challenges that exist for ensuring that this group is not left behind as South Africa takes action towards its global health targets in the post-ART era of UTT and TasP.

Methods

Published literature, policy documents and reports were reviewed and analysed thematically, as were meeting minutes and memos pertaining to the HIV interventions on the farms. A total of 79 in-depth interviews were conducted with key informants, including civil servants and employees of international and local non-governmental organisations, healthcare providers, farm managers and farm workers (Table 1). The farm-based research was conducted on two farms, both of which had been involved in the IOM and MSF programmes. ChiShona[2] was, by and large, the language in which farm workers were most comfortable communicating. As such, two Zimbabwean male research assistants undertook the majority of interviews with farm workers in ChiShona. In addition, non-participant observation of the Department of Health (DoH) mobile clinic was undertaken between May and July 2017. Observations and informal conversations were recorded as field notes. No treatment or care itself was observed. Participant observation in various national and local processes was also undertaken by both authors between 2016 and 2018. This included attending the Vhembe District Migrant Health Forum (VDMHF), a body of various state and non-state stakeholders concerned with issues of migration and health in Musina and the Vhembe District more broadly. Interviews were analysed using Dedoose 8.2.14, and thematic analysis of the interview data, field notes and findings from the desk review was undertaken to identify key concepts and categories. Ethical clearance was obtained from the University of the Witwatersrand Non-Medical Research Ethics Committee, protocol H16/08/10.

Findings and discussion

From humanitarian response to HIV programming

In 2008, Musina was widely considered to be in the midst of a humanitarian crisis (Forced Migration Studies Programme & Musina Legal Advice Office, 2007; Rondganger, 2008). Hyperinflation, political turmoil, and a cholera outbreak had led an increasing number of Zimbabwean nationals to cross the border into South Africa and converge on the border town of Musina (Rondganger, 2008; Staff Reporter, 2008; Tran, 2008), which itself experienced a cholera outbreak in 2008 (Government of South Africa, 2008). In response, international organisations – including the IOM and MSF – established humanitarian programmes in the area to assist the local government (Médecins Sans Frontières, 2013; Vearey & Anderson, 2013). Once the crisis had resolved, in late 2008, both organisations sought to identify vulnerable populations in the area with limited access to health services with which they could work. Both MSF and the IOM identified migrant farm workers as a key population requiring improved access to HIV prevention, testing, treatment and care (Médecins Sans Frontières, 2013; Vearey & Anderson, 2013).

In 2010, the IOM conducted and published the results of an Integrated Biological and Behavioural Surveillance Survey (IBBSS) that they had conducted with workers in the commercial agricultural sector in Musina, as well as in Tzaneen (also in Limpopo) and Malelane (in the neighbouring province of Mpumalanga) (Colvin, 2010). The study highlighted the high prevalence of HIV across all three areas (as mentioned in the introduction, HIV prevalence for farm workers in the Musina area was 28.1%); the prevalence of sexual risk behaviours; prevailing myths around HIV/AIDS; and the poor general health and quality of life experienced by this community. As a response to these findings, the IOM trained over 100 community-based peer educators, referred to as Change Agents, on eight farms. Change Agents are expected to educate and mobilise farm workers around various health related issues, including HIV (de Gruchy, 2019).

Simultaneously, MSF developed and implemented the Musina Model of Care, a mobile clinic programme that provided services at 10 farm "outreach points" – points that were accessible to workers on more than one farm in a particular area (Médecins Sans Frontières, 2013). The mobile clinic was accredited by the National Department of Health (DoH) to test and treat HIV, and included migration-aware elements – for example, providing three months of ART to travelling patients – that aimed to improve continuity of care among migrant farm workers (Médecins Sans Frontières, 2012, 2013).

At the time of writing (June 2019), MSF and the IOM are no longer involved in the management of these programmes. The Musina Model of Care was handed over to the DoH when MSF left Musina in 2013, and the IOM anticipated that the Change Agents would be self-sustaining when, in 2017, the IOM's funding for health-related activities in the area came to an end. However, both interventions have struggled. This is unsurprising given the reluctance of the DoH, at the District and Provincial levels, to support the sub-district in the maintenance of the programme (see de Gruchy & Kapilashrami, 2019 for further discussion). The struggles faced by the Change Agents (discussed in more depth in de Gruchy, 2019) highlight the limitations of programmes that make use of community-based healthcare workers but fail to take into account (1) the need for sustainable funding and (2) the motivations and aspirations of these individuals when they choose to participate in such a programme (de Gruchy, 2019). The broader implications of this (discussed in de Gruchy, 2019; de Gruchy & Kapilashrami, 2019), are that responses to the health of migrant farm workers – including

Table 1: Key informant interviews

Interviewees	Interviews conducted (*n*)
Civil servants (not DoH Musina)	5
Community health workers	3
Farm management	5
Farm workers	43
GlobalGAP	1
Mobile clinic staff	4
National level agricultural sector organisations	2
Non-governmental organisations (local and international)	11
Other	2
Provincial and district level agricultural sector organisations	3
Total	79

to HIV – remain targeted and timebound. Long-term, sustainable migration-aware and mobility-competent responses to health policies and programming, which would ensure the inclusion of this key population in DoH strategies to reach health targets, are lacking.

In addition to the unsustainability of the attempts to improve the access that this key population have to health care, the context within which these migrant farm workers find themselves is one in which a range of structural and intermediary factors limit their access to HIV-related programming.

Determining the health of migrant farm workers: a focus on HIV

Using the IOM and MSF interventions as an entry point, we now lay out the factors that affect access to prevention, testing, treatment and care for HIV and, as such, have relevance for the development of UTT and TasP for this key population. Drawing on (1) the Social Determinants of Health (SDH) framework (Solar & Irwin, 2010); (2) previous efforts to develop migration-aware SDH frameworks (Castañeda, Holmes, Madrigal, Young, Beyeler, & Quesada, 2015; Davies, Basten, & Frattini, 2010; Ingleby, 2012; Vearey, 2013); and (3) literature outlining the determinants of increased HIV risk amongst migrant populations and the challenges migration poses to UTT (Cassels et al., 2014; Hirsch, 2014; Tanser et al., 2015; International Labour Office, 2017; Camlin et al., 2018), we present an adapted framework (Figure 1) that specifically aims to support an improved understanding of and more equitable HIV outcomes for this population.

In the remainder of this section, we build this framework as we show "how social, economic and political mechanisms give rise" to the particular socioeconomic position within which these migrant farm workers are situated (Solar & Irwin, 2010, p. 5). We highlight how this limits access to positive determinants of health and simultaneously increases exposure to the drivers of HIV, as well as outlining the structural complexities that limit HIV interventions with migrant farm workers in South Africa. We end by calling for

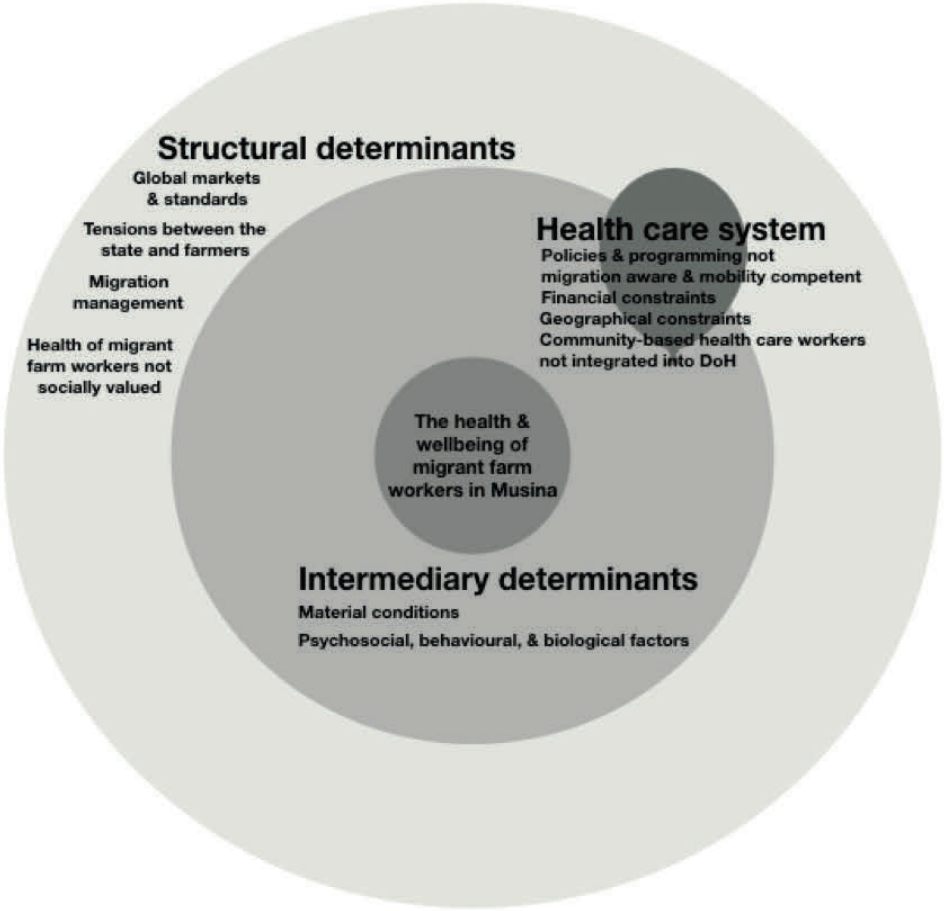

Figure 1: Factors that determine why migrant farm workers are left behind in South Africa's response to HIV.

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the development of migration-aware and mobility-competent responses to HIV. Through an improved acknowledgement of migration, we argue that those implementing HIV interventions will be better placed to improve upon the availability, affordability and acceptability – the access – of care for this key population (Thiede, Akweongo, & McIntyre, 2007; Goudge, Gilson, Russell, Gumede, & Mills, 2009). Consequently, efforts to meet South Africa's global commitments to UHC and the UNAIDS 90–90–90 targets will be better supported (Camlin et al., 2018; Vearey, 2018; Vearey et al., 2017).

The findings are summarised in Figure 1 and described below. First, the structural determinants of health are presented. Here we highlight the macro-level socio-economic and political context within which migrant farm workers find themselves. Second, the intermediary determinants of health are considered, specifically the material circumstances in which this population finds itself and the psychosocial, behavioural and biological factors at play. Finally, the health system, as an intermediary determinant, and its inaccessibility, as both a product of broader structural determinants and the design of the system itself, for this key population is discussed.

Structural determinants

Structural determinants refer to the macro-level, political context within which individuals find themselves and are constrained socially, economically and politically. Understanding the socio-economic and political context within which the agricultural sector operates is central to understanding the HIV risk profile of this population. Through this research, four key structural factors have been identified that, we argue, determine the poor health of migrant farm workers: global markets and standards; tensions between the state and the agricultural sector; the management of migration into South Africa; and the lack of social value that attaches to the health of migrant farm workers.

Global markets and standards

A key concern of the commercial farmers in the area around Musina is the exportability of their produce. In order to export a product, and sometimes sell locally, farmers need to be compliant with standards set by standard owners for agricultural practice. Chief amongst these is Global G.A.P, which, functioning as "*a tool to market access*" (Pvt_02), requires annual recertification of producers in line with their standards. As one research consultant reflects:

> *… the pressure [on farmers] is not coming from within South Africa, from our government or our trade unions or from our employer organisations or agricultural organisations. It's really coming from international trade bodies, so there are things called Global G.A.P. and SIZA (Sustainability Initiative of South Africa) where if you don't meet their standards, you can't trade overseas with Tesco and Sainsbury's and export to all of these places. So especially the fruit industries in Limpopo, all are Global G.A.P. compliant or aspiring to be Global G.A.P. compliant. So they will specify how many water tanks you need to have, how many toilets you need to have [and] where, how many times a year your workers must get tested for poisons in the blood, etc.* (Pvt_01)

However, while some occupational health and safety is of concern to this certification process, "the worker" and his/her health and safety is only of interest to Global G.A.P. (and other such bodies) if it directly affects the product. This echoes findings by London (2003) regarding the regulation and use of chemicals in the agricultural sector – again, the health and safety of the consumer, rather than the worker, is centred in the legislation.

Tensions between the state and the agricultural sector

Regulation of health and safety, as well as of labour conditions, remains the purview of the state. However, while there is a comprehensive network of legislation and policy that is meant to regulate the employment of farm workers, tensions between the state and the agricultural sector often limit the efficacy of these regulations. While there are many facets to these tensions, the ways in which they converge around three specific pieces of legislation are worth discussing.

The first is the *Establishment of the Security of Tenure Act* (*ESTA*) (1997), which has been read as a direct threat to farmers and their business by some:

> *… without any assistance financially from government or from the municipality, a landowner [is expected] to provide tenure security to a farm worker who has been in his employ[ment] for ten years or longer or is older than 60 years … there is not a single other employer in the economic spectrum from which it is legally expected to provide housing and a portion of land to people"* (Agri_03).

The changing requirements with regard to accommodation and tenure security are given as a key reason for the increasing reliance on seasonal and temporary labour in the sector.

The second is in respect of labour legislation inspections. While there are obligations on farm management with regard to working and living conditions under the *Occupational Health and Safety* and *Basic Conditions of Employment* Acts, these are poorly regulated. This is due to a variety of reasons, including the geographic isolation of the farms, which Department of Labour (DoL) employees indicate makes them difficult to access, and the power dynamic between farmers and DoL inspectors: farmers are known to refuse access to inspectors and deliberately obfuscate inspections. A key example of this is through "hiding" workers who may complain to the inspector or not have the correct documentation, by sending them to work on remote parts of the farm during the inspection (DoL_01). This example paints a clear picture of a policy landscape that does not explicitly exclude migrant farm workers from protective regulations, but does fail to take into account the realities of affording them protection and care. As such, the living and working conditions of farm workers are largely left in the hands of their employers.

Finally, in May 2019, the *National Minimum Wage Act* (2018) set the minimum wage for farm workers at ZAR 18 (1, 21 USD CLARIFY MEANING. IS THIS MEANT TO BE US$1.21?) per hour. While the national minimum wage is ZAR 20 (1, 35 USD CLARIFY MEANING. US$1.35?), an

exception has been made for farm workers, alongside domestic workers and employees of Expanded Public Works Programmes. Even with this exemption, some farmers view this as increasing the costs associated with production unfairly, maintaining that it is "*very, very, very difficult for a farmer to pay that amount of money*" (Agri_04), and as an additional reason to employ workers on temporary contracts.

Farmers along the Zimbabwean border have traditionally made use of seasonal labour at specific points of the year when fruit and vegetables have needed to be harvested, but have historically also maintained a permanent workforce. However, given changing legislation around wages, occupancy and a growing interest from consumers in the conditions in which their produce is grown and produced, commercial farmers argue that the cost of maintaining a permanent workforce is too high and are increasingly relying on temporary labour at particular points in the year.

In addition, recent research suggests that a significant number of farm workers in this area are employed without a written contract and earn less than the prescribed minimum wage (Jinnah, 2017, p. 53). Although our research cannot support these findings, as is discussed in the section on "Material circumstances", deductions from workers' pay are not uncommon.

Farm workers in other parts of the country, for example the Western Cape, have in some instances been able to mobilise to try and fight these conditions, with limited success (Donnelly, 2013; South African History Online, 2015). However, mobilisation is uncommon in the area around Musina. On the one hand, this may simply be due to the geographic isolation of these workers. On the other, however, the status of these workers as immigrants and foreigners may play a role.

Migration management

Given the structure of the South African visa and permit system, non-national workers are reliant on farmers for documentation through Corporate Permits. A Corporate Permit is held by the farmer and entitles him to employ and give a permit (valid for a year) to a specific number of non-nationals. In addition, Corporate Permits often do not grant farmers the ability to hire, and therefore provide a permit to, as many workers as they need:

> *We have tried as Zimbabweans using our group to send a plea to the farm owner that, could you please renew our permits. The farm owner responded by saying, it is hard for me to help you because the Government is making it hard for me to help you.* (MFW_EG_103)

In addition, the proximity of the border and roaming military checks renders migrant farm workers particularly precarious (Rutherford, 2008), regardless of whether they are non-nationals or have the correct documentation:

> *… when a person is travelling around, even during … the day, a person can be arrested whenever he comes across the police.* (MFW_EG_103)

Finally, difficulties in accessing documentation pose real limitations on formal employment opportunities for many non-nationals, including Zimbabwean farm workers (Bolt, 2016, pp. 137–158). While many have skills and qualifications from Zimbabwe, they are unable to utilise them within the formal economy in South Africa. Instead, they are limited to manual labour – often referred to as "unskilled labour" – on the farms.

The status of most of these migrant farm workers as non-nationals compounds an already unequal power dynamic between the farmer and the farm worker, and limits the ability of the workers to mobilise for better working and living conditions.

The social value of health

In South Africa, public healthcare for citizens is "seen as a social investment" (Department of Health, 2015, p. 1). This is evident in the state's push for a National Health Insurance (NHI), a change that aims to drive progress towards Universal Healthcare Coverage (UHC). What is also evident from this push is that investment in the health of non-nationals – including migrant farm workers – is not valued in the same way. As it currently stands, SADC nationals in South Africa enjoy the same rights to healthcare as South Africans – they have the right to access free public primary healthcare, and to be means-tested for co-payment when they access higher levels of care. However, the current version of the NHI Bill makes it clear that asylum seekers and undocumented migrants will be entitled only to emergency care under the NHI (Johannesburg Migrant Health Forum, 2016; Vearey et al., 2017).

Interesting, in the Western Cape, the health of farm workers – the majority of whom are South African nationals – is not "seen as a social investment" (Department of Health, 2015, p. 1; see also London, 1998, 2003). While there is broad acknowledgement of the fact that farm workers – both South African and foreign-born – are entitled to care, it is not a political priority. And where successful interventions exist, as was the case with the Musina Model of Care, no political effort is forthcoming to sustain them:

> *… the MEC [Member of the Provincial Executive Council for Health] will come and say if it's possible that the mobile can do this, make it possible that babies are born HIV free, why can't a fixed clinic do that? But hey, all we get is praises … I just wish they can just say "hey guys, here are the resources".* (DOH_03)

What is clear from the disinterest shown by the state in the health of primarily South African farm workers is that both South African citizens and non-nationals often struggle to access care. However, non-nationals face additional barriers as healthcare providers and facility staff are known to target foreign patients with verbal abuse, to deny or delay their access to treatment, or incorrectly to charge them fees (Makandwa & Vearey, 2017; Vearey, 2014; Vearey, de Gruchy, Kamndaya, Walls, Chetty-Makkan, & Hanefeld, 2016).

As such, migrant farm workers in Musina find themselves at the intersection of poorly regulated labour legislation and a xenophobic climate that does not value their health and well-being. Poorly paid and unable to access mechanisms to mobilise, these structural determinants render migrant farm workers particularly vulnerable to poor health.

Intermediary determinants

Intermediary determinants are factors which "flow from the configuration of underlying social stratification and, in turn, determine differences in exposure and vulnerability to health-compromising conditions" (Solar & Irwin, 2010, pp. 36, 37). Here the material circumstances, specifically the poor working and living conditions of farm workers and their geographic and social isolation, are discussed. As is the limited access that migrant farm workers have to positive psychosocial and behavioural determinants of health.

Material circumstances

On the farms around Musina, about 80% of farm workers live in accommodation provided by farmers (Colvin, 2010). "Compounds", as this accommodation is referred to, are characterised by low, poorly ventilated buildings, for which workers are often required to pay rent:

> *These huts that you see and which we are staying in, which are made of mud, we have been paying rentals for them. Even though the iron roofing belonged to me, to use these mud houses we were required to pay rent to stay in them. When heavy rain comes, these mud houses collapse and all our belongings are left in the open, but still they say, you must pay money as rent for these houses.* (MFW_LM_302)

As well as poor waste and water management:

> *With regards to drinking water, there are times, when we have water on the water taps, and there are times when the water taps have no water at all. All what we get is an assurance that, these issues will [be] fixed.* (P_LM_101)
>
> *Toilets have been built for us to enter inside, but, when it is night time, you find other people just defecating on the ground. During the time when these toilets are being cleaned, the dirty water then comes out attracting too many flies. Do you see what I am trying to say? This water, that is used to clean the toilets, flows out, going in different directions.* (MFW_LM_203)

Farms are also often geographically isolated. For example, one of the farms that the mobile clinic visits is a two-hour drive from the centre of Musina, most of which is on poor quality dirt roads that are prone to flooding when it rains. As such, accessing healthcare facilities within Musina, grocery stores, or other infrastructure or services is largely unaffordable, as it usually involves taking a day off work, thus losing a day's wage, as well as incurring travel costs[3]. This is compounded by the stress of having to navigate roaming military and police personnel along the border. Reflecting on how farm workers had to access HIV testing and treatment prior to the arrival of MSF in the area, one farm worker noted:

> *People had to look for money, to enable them to take a ride in cars that go to Musina, and so this meant that if you had no money this would take you some time to access health services.* (CA_LM_102)

This geographic isolation and the financial circumstances in which many migrant farm workers find themselves limits what Solar and Irwin describe as their "consumption potential" (2010, p. 37). In fact, in 2010, the IOM reported that close to 60% of the farm workers in the Musina area disagreed with the statement "I always have sufficient money to buy food for my family" (Colvin, 2010). Reflecting on his ability to return home and see his family, one farm worker noted:

> *I am only able to go home, sometimes, only once, after three months…. Money will not be enough for me to go home [more] often.* (MFW_LM_202)

In addition, work is often subject to a 'no work, no pay' policy, which affects the affordability of taking breaks for any reason, including to access health care when the mobile clinic arrives:

> *Back then we used to have break. But what used to happen was that, after being given a ten-minute break, these ten minutes when clocking would reduce our working hours. So, people decided that it was better to work without a thing called break. We decided to have only lunch.* (MFW_EG_201)

While this research did not focus on the financial circumstances of farm workers, interview data and observation indicate that while no one is well off within the compound, some, particularly families that have one or two permanent workers, appear less financially precarious than others. Remittances were not raised as a concern by the participants in this study, but existing literature indicates that pressure to remit factors heavily in the financial decision-making of migrant farm workers and can result in further economic hardship (Bolt, 2016, pp. 27, 182–206). Within this context, some workers have been able to access additional training or education opportunities through the farm and income-generating strategies on the compound. A key example of this is a couple on one of the farms: she is the Community Health Workers (CHW) (discussed under "Health system") for the farm and runs a hairdressing business, while he was trained by the IOM as a Change Agent, is a fairly senior permanent employee on the farm, and is commonly regarded as a community leader. Her ability to start her business was largely the result of his ability to provide her with some start-up capital. Both have also been able to access opportunities provided by farm management to study via correspondence at local institutions.

Formal education for children on the farms is, however, a concern. While some of the farms in the area around Musina do have primary schools in the compounds, farmers indicate that there is some hesitation from the Department of Basic Education to work with the farm management in the maintenance of these schools. Consequently, some have been shut down, and increasingly children from the compounds are expected to access schools some distance from their homes, resonating with findings from research with farm workers in other parts of South Africa (London, 2003; Kruger, Lemke, Phometsi, van't Riet, Pienaar, & Kotze, 2006).

Psychosocial and behavioural determinants

Research published in 2010 by the IOM indicated that workers in Musina felt safe on the farms and in the compounds, and that there was some level of community cohesion among the workers (2010a, pp. 38–41). Some compound residents, however, generate additional income through the sale of alcohol to workers as well as outsiders

visiting the compounds. This has the propensity to lead to behaviour that endangers others in the compound, including children, and creates some anxiety among compound residents. As a consequence of this, on one of the farms, farm management has limited the sale and consumption of alcohol to specific times on particular days of the week.

One of the most frequently remarked upon benefits of the IOM programme was that the organisation and its implementing partners would often organise weekend activities for compound residents, usually in the form of football games at which Voluntary Counselling and Testing (VCT) was also conducted. Many farm workers argued that these activities improved life for all on the compound:

> *Sports keep(s) people busy. Let me tell you something; if soccer starts at 9 am and ends at 5 pm, even if you wanted to go and see a female friend [have sex], your day would have been finished already. Soccer is like wrestling; everyone wants to watch it.* (CA_EG_201)

This quote also hints at one of the central focuses of the IOM programme, which was to address risky sexual behaviour in the compounds as a risk factor for HIV. High-risk behaviour and the particular gendered vulnerabilities of women in the compound often intersect:

> *… women are the people we abuse, us as people with money or us as people in leadership positions. The reason being that when I see a woman, say she has been out of a job say for two months, I will then say to her, come and have sex with me, so that I can get a job for you. I will then get her a job after sex, this then means that I am already infected with a sexual sickness, and I am now spreading it.* (CA_EG_201)

This echoes work done around the link between material deprivation and risky sexual behaviour in poor urban areas (Greif, Dodoo, & Jayaraman, 2011; Greif, 2012; Kamndaya, Thomas, Vearey, Sartorius, & Kazembe, 2014; Kamndaya, Kazembe, Vearey, Kabiru, & Thomas, 2015): while migrant workers were not more likely to be HIV-positive than non-migrants at an individual level, HIV prevalence remains highest among migrant communities, specifically migrant farm workers (Colvin, 2010, pp. 56–57).

Health system

As illustrated in Figure 1, the health system is mediated by both the structural and intermediary determinants of health. The social determinants approach argues that while structures that are broader than the health system determine an individual and population's health and well-being, the health system remains a key determinant of health. This section uses the Musina Model of Care as a lens through which to unpack the factors that render the health system inaccessible to migrant farm workers in this area.

The Musina Model of Care

In 2009, when MSF implemented the Musina Model of Care, their mobile clinic programme, the local DoH already ran a mobile clinic that visited farms and schools in the area around Musina. However, like most mobile clinic programmes that serve South Africa's rural populations, this programme was not certified to provide HIV treatment, nor did it take into account the realities of providing care to a highly mobile population.

There were three central components to the MSF programme, one of which was the provision of HIV testing and treatment to farm workers. The second was the inclusion of strategies to address the effects of mobility and migration on continuity of care:

> *Patients were provided with patient-held health records and asked about their travel plans at each visit. If they were returning to Zimbabwe, MSF provided information about ART sites nearby. Those planning to travel for more than two weeks were classified as a temporary transfer out (TTFO) and were given a three month supply of antiretroviral therapy (ART), one week of tail protection (a strategy to prevent resistance if treatment interruption is unavoidable), and a transfer letter. Counselling materials were designed to help patients understand possible changes in regimen and formulation over time.* (Médecins Sans Frontières, 2013, p. 7)

The third was the training and development of a cadre of Community Health Workers (CHWs). Based in the compounds, this group of community-based healthcare providers were trained to offer basic first aid, facilitate support groups for HIV-positive patients, and, most importantly, to provide a link between farm workers and mobile clinic staff.

By the end of 2013, the Musina Model of Care merged with the local DoH programme and was handed over to the DoH, which is now able to provide ART through the programme. In 2017, the manager of the mobile clinic reported that they had over 3 000 patients on ART. However, the DoH has struggled to maintain aspects of this programme in the wake of MSF's departure (de Gruchy & Kapilashrami, 2019). Four central features of the healthcare system have both undermined the sustainability of the Musina Model of Care and, more broadly, hampered efforts at improving the health and well-being of migrant farm workers in South Africa.

First, as a consequence of the broader political and social context, health policies and programmes within South Africa do not take into account the realities of migration or recognise the role that migration plays as a determinant of health (Vearey, 2014; Vearey et al., 2017). This includes the need for medication, particularly chronic medication, to be available to individuals as they move for work, or return home due to ill-health or for Christmas (Vearey et al., 2017). For cross-border migrants, their treatment at the hands of frontline staff at healthcare facilities, who, due to their own xenophobia, often deny or delay care to foreign patients, verbally abuse and incorrectly charge them, further limits their access to care (Vearey, 2014; Makandwa & Vearey, 2017). While the Musina Model of Care was able to overcome some of the more practical barriers to continuity of care, within a broader context of disinterest in this key population the successes of the programme have not been used to inform policy or practices targeting similar populations.

Second, the DoH is constrained financially. Since 2012/13, the DoH has operated with an increasingly reduced budget that has influenced which aspects of the health system have been prioritised (Blecher, Daven, Kollipara, Maharaj,

Mansvelder, & Gaarekwe, 2017). While primary health care has remained a priority, one of the ways through which costs have been cut has been through reducing the numbers of people employed in the system (Blecher et al., 2017, p. 29). While the DoH is financially constrained nationally, the health system in rural areas is particularly hampered, affecting the availability of care (Gaede & Versteeg, 2011, p. 102).

Third, hiring and retaining staff in rural areas is a struggle (Rural Health Advocacy Project, 2017). As a Vhembe District DoH Director explained in relation to retaining staff in Musina:

> *So, one of the issues that really gives us a problem as health is that it's very difficult to recruit health professionals this side. I'm not quite sure in terms of the numbers, but … it's very difficult, it's very hot this side, there are issues of infrastructure, there's no accommodation units for our health professionals.* (DoH_01)

Finally, while the state does acknowledge that interventions at a community level are a vital component in ensuring the availability, affordability and acceptability of health care to rural populations, there has been limited support from the state to maintain and sustain such programmes (Clarke, Dick, & Lewin, 2008; Schneider, Hlophe, & van Rensburg, 2008; Gaede & Versteeg, 2011; Lehmann & Gilson, 2013; de Gruchy, 2019; de Gruchy & Kapilashrami, 2019). For example, while MSF had hoped that the state would take over the maintenance and administration of the CHWs after MSF's departure, the DoH argued that it was unable to do so. As such, the CHW programme has been passed between and managed by three non-governmental organisations (NGOs) in the five years since MSF's departure, and CHWs have struggled without sustained involvement and support (de Gruchy, 2019; de Gruchy & Kapilashrami, 2019).

Conclusion

Globally, and in South Africa, the health of migrant farm workers is not prioritised, indicating that equity in health remains a distant reality, which has particular implications for HIV. This article shows how, in the case of the Musina sub-district, the structural context within which migrant farm workers live and work is one that places little value on their health and renders them reliant on their employers for documentation, accommodation, access to services and safe working conditions, with very little oversight from or recourse to state regulation. As a result of this structural context, migrant farm workers struggle to access positive intermediary determinants of health. Most worryingly, the public healthcare system is unable to penetrate this context due to both its own structural constraints, and what is best described as an apparent disinterest in recognising and responding to the realities of migration and mobility, migrant labour, and HIV in the country and region (Camlin et al., 2018; Vearey, 2014; Vearey et al., 2017; Vearey, 2012). As such, migrant farm workers are 'left behind' in South Africa's response to HIV. Perhaps most troubling is that these findings are unsurprising, they support existing literature that has identified the challenges faced by, and the disinterest of, the South African public healthcare system in developing migration-aware responses to health, including to HIV (Camlin et al., 2018; Cassels et al., 2014, 2018; Vearey, 2018).

A social determinants of health approach makes clear that the broader structural context beyond the DoH plays a key role in the particular vulnerabilities faced by this population. This broader context must be acknowledged and improved, to improve the health status not only of migrant farm workers, but of all in South Africa. Engaging with the historical and political context within which the health of migrant farm workers is jeopardised, including the regulation of the sector with regard to occupational health and safety and living conditions, is essential. If South Africa is to meet its global commitments to UHC and the UNAIDS' 90–90–90 targets, policies and programming must be migration-aware and mobility-competent. Successful implementation of migration-aware UTT and TasP interventions with key populations – including migrant farm workers – will benefit all who live and work in SA and SADC.

Acknowledgements – The authors thank all those who participated in this research, particularly those working with the mobile clinic programme in Musina. They also thank Anuj Kapilashrami for her continued support and supervision of TdG, and Lenore Longwe for her administrative and logistical support during the research process. This work was supported by the Wellcome Trust under Grant 04868/Z/14/Z, an Investigator Award held by Jo Vearey.

Notes

[1] Angola, Botswana, Comoros, the Democratic Republic of Congo (DRC), Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe are the 16 member states of SADC.

[2] A language widely spoken in Zimbabwe.

[3] This trip reportedly costs between 60 and 150 ZAR (US$4–11 at the time of writing).

ORCID ^PROVIDE IF AVAILABLE^

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5 Paper two - After the handover: Exploring MSF's role in the provision of health care to migrant farm workers in Musina, South Africa

This paper, co-authored with Anuj Kapilashrami and published in *Global Public Health*, uses the Musina Model of Care as a case study through which to build and explore two of the key findings that emerged as central to this research. The first, and primary focus of the paper, is that non-state interventions are timebound, localised, and not politically supported by state structures. The second, is that state responses to the health and wellbeing of migrants are usually crisis-bound and targeted.

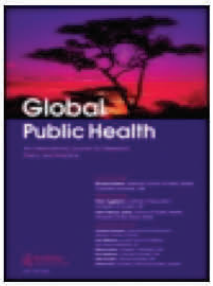
This paper is situated within the literature discussed in detail in section *2.4 The involvement of (international) non-governmental organisations in healthcare provision*, which highlights the various challenges associated with the involvement of humanitarian organisations, United Nationals (UN) agencies, and funders in local contexts in Low- and Middle-Income Countries (LMICs).

Drawing heavily on interview data, non-participant observation, and an analysis of the grey literature around the Musina Model of Care, including meeting minutes, memos, and project reports, this paper raises two questions in response to the emergent themes. In acknowledgement of the time- and crisis- bound nature of both state and non-state responses to health, the first asks what it means for healthcare service provision and the health and wellbeing of migrants if interventions to improve their access to healthcare are not sustainable. Building on this, the second asks what the implications may be of responding to migration and health in ways that exceptionalise migrants and tie the moments at which their health and wellbeing are prioritised to moments of crisis. In response, we suggest that this may have the potential to undermine their access in the long-term, as well as to undermine calls for the development of migration-aware health policies and programming in general.

This paper provides an example of what responses to the health and wellbeing of this community specifically, but to migration and health more generally, look like in response to Paper One (de Gruchy & Vearey, in press). Paper One, which lays out the social and political landscape within which migrant farm workers in Musina find their access to both positive determinants of health and the healthcare system limited,

argues that migration-aware and mobility-competent health policy and programming is necessary to improve the access that migrant communities have to healthcare. In lieu of proactive migration-aware policies and programming, this paper provides a key example of what current responses to migration and health exist.

The limitations of the current model of intervention and response that this paper raises work in conjunction with Paper Three (de Gruchy, 2019), to clearly articulate the unwillingness of the state to sustain programmatic interventions that could improve the health and wellbeing of migrant communities. Finally, this paper and the questions it raises provide a key building block for the conceptual analysis of the policy process found in Paper Four (de Gruchy, submitted) and the Conclusion of this PhD.



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Global Public Health
An International Journal for Research, Policy and Practice

ISSN: 1744-1692 (Print) 1744-1706 (Online) Journal homepage: https://www.tandfonline.com/loi/rgph20

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To cite this article: Thea de Gruchy & Anuj Kapilashrami (2019): After the handover: Exploring MSF's role in the provision of health care to migrant farm workers in Musina, South Africa, Global Public Health

To link to this article: https://doi.org/10.1080/17441692.2019.1586976

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Published online: 05 Mar 2019.

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GLOBAL PUBLIC HEALTH
https://doi.org/10.1080/17441692.2019.1586976

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After the handover: Exploring MSF's role in the provision of health care to migrant farm workers in Musina, South Africa

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ABSTRACT

Non-state actors, including humanitarian agencies, play a prominent role in providing health care in low- and middle-income countries. Between 2007 and 2009, Musina, a South African municipality bordering Zimbabwe, became the site of several interventions by non-state organisations as an unprecedented number of Zimbabweans crossed the border, putting strain on already burdened local systems. After the initial need for humanitarian relief dissipated, organisations started to implement projects that were more developmental in nature. For example, Médecins sans Frontières developed a mobile clinic programme to improve health care access for migrant farm workers, a programme that was subsequently integrated into the Department of Health. Since the handover of the programme, it has faced multiple challenges. Using qualitative methodology and a case study approach, this paper traces the development of the programme, exploring the changing relationship between MSF and the state during this time. This research raises questions about the implications of short-term 'innovative' interventions targeting the access that migrants have to care, within a context in which policy and programmatic responses to health are not migration aware. Furthermore, it highlights the ways in which the energies and resources of local DoH employees were redirected by MSF's involvement in the area.

ARTICLE HISTORY
Received 23 November 2018
Accepted 17 February 2019

KEYWORDS
Migration; migration and health; critical humanitarianism; South Africa; Médecins sans Frontières

Introduction

Within South Africa, as in many low- and middle-income countries, the provision of health care by the state is often accompanied by non-state intervention, specifically in the form of non-governmental organisations. These interventions are usually portrayed as either humanitarian, in response to 'disruptions and emergencies, such as war, famine and natural disasters, with an emphasis on the short term' (Crewe & Axelby, 2013, pp. 3, 4) or developmental, where the idea is 'to produce long-term social, economic or political change' (Crewe & Axelby, 2013, pp. 3, 4). Médecins sans Frontières (MSF), the organisation at the centre of this paper, have traditionally engaged in work that is more humanitarian in nature. However, the boundaries between the two sectors are increasingly blurring with shifts in broader discourses underpinning their approaches. As Crewe and Axelby (2013) argue, 'development usually involves some shorter-term aid – helping the poorest families out when they are destitute – and humanitarian aid often aims for longer-term service provision' (pp. 3, 4).

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One of the key critiques of development initiatives tied to international funding has been around the ways in which they disrupt both local state structures and civil society. Scholars have highlighted the results of disparities in salaries and working and living environments between agency staff and local civil servants (Pfeiffer, 2003) and the ways in which public infrastructure is weakened by state employees taking up better paying jobs and opportunities with international non-governmental organisations (iNGOs) (Kapilashrami & McPake, 2013). Empirical research has also shown how larger iNGOs can detract attention from smaller local organisations (Bruno-van Vijfeijken, Lux, Neupane, & Singh, 2017) and how international initiatives, like the Global Fund through, what Kapilashrami and O'Brien refer to as, their 'dictating regime' (2012) shape the agendas of both local civil society and the state. Through funding cycles and associated conditions, specific kinds of work and approaches are prioritised (Younis, 2007), and attendance at trainings and workshops tied to specific projects and their deliverables is demanded (Kapilashrami & O'Brien, 2012; Pfeiffer, 2003).

This critique has primarily focused on interventions linked to development and health aid. Critiques of humanitarian aid, on the other hand, have traditionally been far more concerned with the relationship between the organisations and their 'expatriate' and 'local' workforces (Redfield, 2012, 2013), as well as these organisations' changing understanding of themselves and their duty to interfere, during what is perceived to be a humanitarian crisis (Fassin, 2010; Fox & Goemaere, 2006). However, as the narrative around what constitutes a 'crisis' has changed, specifically in relation to HIV/AIDS and migration, the form and substance of humanitarian interventions have started to change. Within the South African context, for example, MSF has maintained a presence and provided HIV and TB care in Khayelitsha, an informal township in Cape Town, since 2001, and has a secondary aim of 'influencing local, national, regional and international policies on treatment for these diseases' (Médecins Sans Frontières, n.d.). Understanding the longer term implications of these interventions, traditionally the interest of critiques of development interventions, is therefore imperative.

Using a case study of MSF's involvement in Musina, a South African town bordering Zimbabwe, this paper traces the development and sustainability of the programme and looks at the longer-term implications of MSF's intervention for the local Department of Health (DoH). This case study explores the changing relationship between MSF and the state during this time. It highlights the ways in which the energies and resources of local DoH employees were redirected by MSF's involvement in the area, and interrogates how this has changed since MSF's departure, specifically in light of the different approaches that MSF and the DoH have taken in the management of the programme. Furthermore, it raises important questions about the exceptionalisation of migrants through such targeted programmatic interventions.

Migration and health in Musina: Before and after 'crisis'

Bordering Zimbabwe, Vhembe District Municipality is a space in which cross-border migrants are particularly visible, specifically in the town of Musina. Between 2007 and 2009, the number of Zimbabweans crossing the border and converging on the town peaked due to electoral violence and a widespread cholera outbreak, putting a strain on local systems and structures. In December 2008, Vhembe District was declared a disaster area in the wake of a cholera outbreak in Musina and surrounding areas (Vearey & Anderson, n.d.). In response, many international organisations, including MSF, the International Organization for Migration (IOM), the United Nations High Commissioner for Refugees (UNHCR), and Save the Children UK, moved into the area to respond to 'the coalface of humanitarian crisis' (Rondganger, 2008). In this period, these organisations focused on providing emergency health care, assisting with documentation, and monitoring the detention and deportation of immigrants.

Once the initial 'crisis' was over, as the number of Zimbabweans steadied and then decreased in Musina, many of these organisations remained, with a renewed focus on longer-term concerns. MSF shifted its focus from providing access to emergency medical care to improving the access that

migrant farm workers around the town had to general and comprehensive health care, through putting in place mechanisms which could be maintained by local structures once the organisation left. This resonates with Steinberg's reflections on MSF's intervention in Lusikisiki, on the South African coast, about which he writes 'it's goal … was to show that ordinary nurses, not rich international NGOs, could administer a treatment programme' (Steinberg, 2008, p. 87).

Whilst South Africa has a functioning public health care system, this system is faced with the 'so-called four colliding epidemics' – HIV and tuberculosis (TB); injury and violence; chronic illness and mental health; and maternal, neonatal, and child health (Mayosi et al., 2012). Furthermore, until 2009, state policy was characterised by HIV/AIDS denialism, which provided ample room for actors like MSF to engage in both advocacy and health care provision (Redfield, 2013, p. 246). Since 2009, the state has made strides in rectifying its previous position on HIV. However, South Africa still has a high incidence rate for both TB and HIV; violence remains rife (Mayosi et al., 2012); and the burden of non-communicable diseases in the country is growing (Mayosi et al., 2009). Furthermore, health policy within South Africa (and across the region) has failed to account for the realities of migration and recognise migration as a determinant of health (Vearey, 2014; Vearey, Modisenyane, & Hunter-Adams, 2017). Migrants, both cross-border and internal, face barriers to care, as systems do not take into account their mobility and temporary nature of residence, including the need for patients to be able to access medication, particularly chronic medication, as they move for work, due to ill-health, or simply return home for Christmas (Vearey et al., 2017). For cross-border migrants, access can be further undermined by their treatment at the hands of frontline staff at health care facilities, who often deny or delay care to foreign patients, verbally abuse and incorrectly charge them (Makandwa & Vearey, 2017; Vearey, 2014).

In addition, since the mid-1990s, the DoH has been restructured to reflect a decentralised approach to governance and administration. Decentralisation, described by McIntyre and Klugman as 'the transfer of responsibility for planning, management and financing from central government to peripheral levels of government' has been a key approach in health sector reform in South Africa, as in other low- and middle-income countries over the past decade or more (2003, p. 109). However, within the South African DoH, decentralisation has been deemed ineffective and has invoked strong feelings of resentment and disempowerment among civil servants at district and facility level as staff are expected to implement policies, with very little forewarning and insufficient resources, but remain excluded from decision-making processes (McIntyre & Klugman, 2003; Walker & Gilson, 2004).

Within this context, there have been many opportunities for non-state actors to engage with the provision of health care and advocate for improved access – opportunities which, at various points, MSF has taken. Against this backdrop, this paper investigates the changing relationship and dynamics between MSF and the state agencies, and the implications of this since MSF's departure from Musina in 2013.

Methods

This paper forms part of a larger qualitative study of the programmatic and policy responses to migration and health in Musina. This paper focuses on the development of a MSF-led mobile clinic programme, the Musina Model of Care, and uses it as a lens through which to understand the relationship between MSF and the state.

Findings reported in this paper draw on fieldwork conducted between January and November 2017 (with some initial scoping work having been done in 2016, and some follow up being done in 2018) on two farms in the area around Musina, in Musina itself, in Polokwane (the Provincial capital), in Pretoria and Cape Town, and over Skype. This paper draws on data from 79 key informant interviews (see Table 1), published and grey literature collected during the research, and observation of the programme.

The grey literature, described by Adams *et al.* as second and third tier literature (Adams, Smart, & Huff, 2017), consulted for this study included emails, memos, and project reports that provided

Table 1. Key informant interviews.

Category of respondent (alphabetical)	Number of interviews
Agricultural sector organisation	5
Civil servants (not DoH Musina)	5
Community Health Workers (CHWs)	3
DoH Musina	4
Farm management	5
Farm workers	43
Local NGOs	4
Médecins sans Frontières (MSF) (current and former employees)	5
Other	5
Total	79

information about the projects, and insights into the relationship between MSF and the DoH. These were analysed in relation to published literature pertaining to MSF, as well as iNGOs more generally, and literature about the structure of the South African state, specifically in relation to the health care system.

Observation of the mobile clinic programme was undertaken between May and July 2017. Given the nature of work in the mobile clinics, conducting in-depth interviews with services providers in the programme was difficult and obstructed their work. As such, observation and informal conversations with staff recorded as field notes were used to engage with questions around the continuity of the programme since the departure of MSF. No treatment or care itself was observed.

Analysis of this data was undertaken using thematic analysis, the identification of codes and themes through a reading and examination of the data (Fereday & Muir-Cochrane, 2006). The emergent themes which have shaped this paper include the relationship between MSF and the DoH mobile clinic employees, experiences of providing care to migrant farm workers, and MSF and the DoH's perceptions of the Musina Model of Care and its importance.

Ethical clearance was obtained from the University of the Witwatersrand Non-Medical Research Ethics Committee (REC), protocol H16/08/10. In line with the commitments laid out for the REC, informed consent was sought prior to interviews, observation, and access to grey literature.

In the following sections, we lay out and explore the development of the Musina Model of Care and MSF's involvement in Musina. We present this narrative chronologically in the Results section, for ease of understanding and to highlight the ways in which the relationship between the state-run mobile clinic and MSF changed. We conclude the paper by discussing the broader implications of our findings for migrants' health and for our understandings of humanitarian interventions.

Results

Why healthcare for migrant farm workers?

Once the initial 'crisis' in Musina had passed, MSF looked for other ways in which they could intervene in the area. In 2009, the organisation decided to improve the access that migrant farm workers, living and working, either temporarily or more permanently, on the commercial farms in the area surrounding Musina had to health care.

Access to health care for migrant workers, who have crossed the border into South Africa since the 1970s and found work on the commercial farms in the area (Bolt, 2016; Rutherford, 2008a), has traditionally been very limited (Médecins Sans Frontières, 2012, 2013). Research by IOM indicated that at this time, HIV prevalence within these communities was as high as 28.1%, nearly double the prevalence of Vhembe District – 14.7% (International Organisation for Migration, 2010, p. 9). Many workers lived, and continue to live, in 'compounds' on the farms, accommodation provided by farm management, which are often 50 kilometres from the nearest healthcare facility. Compounds are characterised by poorly ventilated accommodation, and limited and makeshift sanitation facilities.

Furthermore, the geographical isolation of workers on these compounds means that access to health-care facilities is restricted as it usually involves taking a day off work, thus losing a day's wage and incurring travel costs.[1] Should blood tests or chronic medication be needed, this would require frequent trips adding to the cost. For Zimbabwean workers, there is the additional stress of having to navigate roaming military and police personnel along the border. Although some do have the relevant documentation, this does not necessarily protect them from harassment or deportation (Rutherford, 2008b). As one farm worker reflected in response to questions about seeking health care prior to the involvement of MSF in the area:

> People had to look for money, to enable them to take a ride in cars that go to Musina, and so this meant that if you had no money this would take you some time to access health services. (CA_LM_102)

Prior to the arrival of MSF, the DoH had provided some care to the worker communities by way of a mobile clinic. However, until the intervention of MSF, this mobile clinic programme, which was meant to visit farms on rotation, was not accredited to provide antiretroviral therapy (ART). Furthermore, there was little awareness among the farm workers about the programme and its purpose:

> Their vehicle used to come here and we saw it, but we did not know what were they here for … It would come and be parked here for about two hours … and then you would see it leaving, without anyone having accessed health services. (CA_EG_203)

Developing the Musina model of care

Acknowledging the limitations described above, and wanting to address the particular needs of the migrant farming community, MSF established their own mobile clinic programme, which they called the Musina Model of Care. This was described by MSF as a project through which they could demonstrate 'innovation', which they hoped would lead to changes in the ways in which the DoH made care accessible to migrant farm workers specifically, but rural population groups more generally (iNGO_01). As such, the MSF clinic ran parallel to the DoH one but differed from the state programme in three respects.

First, the programme extended the scope of care provided to farm workers by providing HIV testing, counselling, and ART,[2] by most accounts being the first mobile clinic programme in South Africa to do so. At this time, the state-run mobile clinic provided antenatal, maternal, and child health care, as well as TB treatment. To be tested for HIV or initiated on ART, farm workers had to make the trip to one of the facilities in Musina.

Second, MSF argued that the practices adopted by the Musina Model of Care were innovative and took into account the realities of migration and its affect on continuity of care, a feature lacking from state responses:

> Patients were provided with a patient-held health record and asked about their travel plans at each visit. If they were returning to Zimbabwe, MSF provided information about ART sites nearby. Those planning to travel for more than two weeks were classified as a temporary transfer out (TTFO) and were given a three month supply of antiretroviral therapy (ART), one week of tail protection (a strategy to prevent resistance if treatment interruption is unavoidable), and a transfer letter. Counselling materials were designed to help patients understand possible changes in regimen and formulation over time. (Médecins Sans Frontières, 2013, p. 7)

Government health care providers and farm workers all confirmed these aspects of the programme.

Third, as part of their response, MSF asked compound residents to identify individuals who they felt would best perform the duties of a full-time Community Health Worker (CHW) (iNGO_06). As members of the compound community, CHWs were envisaged as acting as a 'vital link between the farm community and the mobile PHC nurses', testing for HIV, providing counselling for HIV and TB, promoting awareness, and facilitating support groups for workers on ART (Médecins Sans Frontières, 2013, p. 8). Ten individuals, situated either within a large compound or in an area where several compounds adjoined, were trained and paid a stipend by MSF to act as a link between the mobile

clinic nurses and the workers, and insure that basic health care was still accessible between clinic visits (Médecins Sans Frontières, 2013). Support groups, or patient adherence groups would meet on Sundays, and, while they were run by CHWs, were often attended by nurses from the mobile clinic. Findings from a study of support groups attached to the MSF project in Khayelitsha found that these groups lead to 'improved retention on ART and decreased rates of virologic rebound' (Luque-Fernandez et al., 2013, p. 4). As in Khayelitsa, interview data showed that this arrangement worked for both workers, who no longer needed to take time off work to collect their medication, and for nurses, who felt that they are able to offer a better service to their HIV positive patients and who were able to claim overtime.

Working with the DoH

The implementation of this programme and MSF's presence in Musina was initially met with suspicion and hesitation from staff implementing the state mobile clinic programme. The manager of the state programme reported both an unease among the state employed health care providers towards a 'competing' programme, but also frustration with the Provincial administration and MSF for not managing the process better:

> You know that change is pain … my staff members, they thought that MSF is here to take their jobs … and their (MSF's) attitudes towards the sub-district, it was not an easy thing. Because, people, they did not understand much. Because seemingly the MOU (Memorandum of Understanding signed between MSF and the state) was just from the Province down to the ground, not even involving other people around. And they (MSF) did not establish themselves when they arrived here; they did not knock on the door to see who's here (providing services in the area), they just pushed to the farms. So the relationship at first was not … OK. I had to mediate between the two, so that each party understands that there's nobody here to take another person's job, it's just to take the services to the patients, and MSF is here temporary; they are going and we're the custodians of the project. (DOH_01)

MSF's project co-ordinator, on the other hand, was critical of the state in which they found the DoH programme. She referred to absenteeism amongst the nurses, a 'problem with team dynamic', the team being 'under resourced in just about every sense', and a disinterest and lack of motivation on the part of the health care providers, specifically in relation to treating foreign patients (iNGO_03).

However, MSF's involvement in Musina was only short term. To ensure the longevity of the Musina Model of Care, and its innovative approach to health care access for migrant farm workers, MSF started working with the DoH mobile clinic programme in 2010. A series of workshops, trainings, and meetings were thus held between the two teams, who managed to start working together. This included, in 2011, MSF paying for ten registered nurses to partake in a DoH accredited sexual assault nursing course.[3] A former MSF employee describes this process:

> You know when you're starting anything at first there's not that trust or that fear of the unknown, and then you'll be like 'OK, who are these guys?'. I think now we're working together, the team like every Friday we'll have like refresher courses. So we'll include both the Department and MSF, and we start interacting and getting to know each other so when we go to the field it's more easier than you guys just coming in your car and the MSF guys and then we meet in the field. It's a little bit awkward … so it started from, I wouldn't say it was smooth sailing ja [yes], but slowly, slowly we became a team. (iNGO_07)

The impetus for the coming together of the two programmes is described slightly differently by the DoH programme co-ordinator and MSF. For the former, it was as a consequence of the duplication of services that was seen when the programmes worked in parallel, while for MSF, it was imperative to ensure the longevity and sustainability of their programme. These different rationale notwithstanding, both state and MSF employees saw the coming together of the two programmes as an extremely positive development. Former MSF employees describe the relationship that developed between the two teams as familial; 'so there are some people we are still communicating, and we're so close, we are family' (iNGO_07), 'we were just one family' (iNGO_06). Likewise,

government nurses reflecting on the relationship between the two teams described MSF employees in warm and positive ways. Members of the MSF team were described as 'colleagues' and as 'helpful'; 'they were helping us with transport, everything … I think those people were helping a lot', and the process of MSF leaving the area, in 2013, as 'painful' (DOH_04).

The handover

MSF's departure from the area was carefully curated and characterised by a handover process that took two and a half years. Both civil servants and MSF acknowledged the time-bound nature of MSF's intervention, with a participant from the Office of the Premier[4] noting that the 'government actually has to sustain itself'. Importantly, while the programme was technically handed over to the Provincial DoH, interviews with DoH employees revealed that the Provincial authorities were not involved in the practicalities of the handover. This process was left to the district and sub-district.

MSF described this handover process as 'a progressive reduction of presence' (iNGO_01), during which time MSF employees report undertaking a significant amount of capacity building, as well as scaling down the range of services that they had been providing so that the DoH could realistically take over the programme (iNGO_03). This process was planned out using a 'dashboard', on which the 'sequence of the handover was sketched out' and used to monitor progress (DOH_01; iNGO_03). It involved an integration of the services that the two programmes were offering, skills development and training for DoH staff, and a reduction in the number of farms and staff for outreach visits (iNGO_01). During this process, MSF also reported having to 'lobby' the state about the importance of providing care for migrant farm workers, and consequently the need to support the continuation of the Musina Model of Care (iNGO_03). MSF argue that whilst the state employed mobile clinic team was invested in the programme, the District and Provincial level DoH were less willing to redirect resources, and potentially reconsider priorities and policy.

In this process, the CHW component was delinked from the rest of the programme. At the time of MSF's departure, the DoH argued that it was not in a position to take over the management of these workers. Consequently, the management and administration of the programme was handed over to North Star Alliance, an iNGO that provides health services to mobile workers, primarily targeting truck drivers through a series of 'Roadside Wellness Centres' (North Star Alliance, 2015).

Reflecting on their departure from Musina and the importance of the handover process, a senior member of MSF in South Africa justified the short term nature of their intervention by explaining how the organisation saw their role as one of innovation rather than 'system strengthening':

> the aim of our operations isn't to permanently replace provision of services by the national Department of Health. Rather it's to demonstrate a model for some kind of service provision that's replicable and that we're able to hand over. (iNGO_01)

After the handover

This research commenced three years after the handover was completed. Although the state-run mobile clinic continues to refer to itself as the Musina Model of Care and to provide ART to migrants living and working on the farms, many of the components of the programme, those which made it particularly innovative, have struggled in the wake of MSF's departure.

In 2017, when interviewed about the success of the programme, a senior MSF employee credited close collaboration between MSF and the DoH, as well as the mobile clinic manager, with the programme's survival and continued success:

> I think this is probably one of the reasons that it's survived; so the teams going out were a mixture of MSF staff and DoH staff, so we were able to train and mentor DoH staff. And you can see from [her] (mobile clinic manager) and her team that the model has really survived. And I think it's worth saying that to me it really shows the importance of these kinds of champions. (iNGO_01)

However, this ignores the material advantage that MSF's presence had for the programme. Practically, MSF's involvement brought with it a large team that included individuals whose sole purpose was to organise the logistics of the programme, set up equipment, and drive the clinic from farm to farm, alleviating the nurses of these responsibilities. The driving in particular is deemed strenuous, as the roads between Musina and the surrounding farms are of a poor quality, and the distances between destinations mean that some farms are a two-hour drive from the offices from which the clinic departs each morning. The issue of transport was a key issue to which respondents returned throughout the research. For the DoH nurses, MSF's involvement in and support of the programme was characterised by their provision of vehicles, as one nurse notes 'when they were here, transport was not a problem. If we didn't have transport, they'd come and pick us up'. And consistent problems with transport serve as a constant reminder of MSF's departure. Whilst the programme has access to three vehicles, Toyota Quantums, these are frequently in need of repairs (echoing findings from mobile clinic programmes in other parts of the country, Stemmet, 2016). Furthermore, several nurses reported that they had clear instructions from the DoH that should they drive in the rain, they remain liable for any mishap or accident on the road.

The provision of care has also become more stressful since MSF's departure as teams are smaller. Additionally, in the beginning of 2018, the mobile clinic manager, who was so strongly praised by MSF, and remains an advocate of the Musina Model of Care, was redeployed within the DoH and as such is no longer based in Musina. Her replacement has stopped nurses attending support group meetings over the weekend due to budget constraints. Workers on ART are expected to collect their medication during the clinic's weekly visit, putting additional stress on these visits, or travel to Musina over the weekend.

Finally, it is worth noting how the CHW programme has fared since MSF's departure. Since 2013, the CHW programme has been managed by three different organisations. In the wake of MSF's departure, North Star Alliance volunteered to manage eight of the ten CHWs for a year, whilst the remaining two were taken on by a third organisation – the Treatment Action Campaign – as 'health mobilisers'. A year later, the programme was handed over to a local NGO, the Centre for Positive Care (CPC), who were able to secure DoH funding to cover stipends for the CHWs. Since the beginning of 2018, the administration of the CHWs has been taken over by the Red Cross, although research participants have reported that there has been very little engagement from the organisation on the ground. No explicit reasons were provided for these frequent changes in management. Meeting minutes and interview data did not evince particular interest or expertise in CHWs among these organisations. Instead, it became clear that these were ad-hoc arrangements put in place to fill in the void created by the departure of a host organisation or its diminishing capacity to manage the programme. For example, at the time of MSF's departure, meeting minutes indicate that North Star Alliance had PEPFAR funding, one of the purposes of which was to 'undertake a project focused on migrant farm workers in the Musina area', and as such 'wishe[d] to assist DoH in sustaining MSF's model of care'. Although many of the farms still have CHWs, some of the original MSF-trained cohorts have left, either in search of better (paid) work or for personal reasons, and on one of the farms in particular farm workers were highly critical of the quality of the CHW's work in more recent years and have become increasingly reliant on the mobile clinic nurses.

Despite these changes, when asked to reflect on whether they thought that the departure of MSF had had an affect on the services that they were able to provide, nurses were quick to respond that they did not. Often adding, for example, 'we are doing everything they were doing, even though we are lacking there because of transport, we are trying our best' (DOH_04). Civil servants who were not directly involved in the programme were a bit more critical about how it had fared since MSF's departure, noting that

> the level of service delivery really has gone down. Because of, you know, the Department struggling on it's own to provide services. Ja [yes] they are so stretched … transport wise, even personnel … the impression that I got

is that they are experiencing more difficulties since the leaving of the Doctors without Borders [MSF]. (OTP_01)

Discussion and conclusion

In the immediate wake of MSF's departure, the programme was, in many ways, able to continue as it had during MSF's involvement, and mobile clinic staff did not complain about the additional workload. However, without renewed support and the replenishment of resources from the state and other administering organisations, various parts of the programme have started to come undone, bringing its longer term sustainability into question: vehicles need replacing; nurses have left the DoH or Musina and not been replaced; the time that nurses get with patients has been curtailed; and CHWs are unable to provide the support they once did to the mobile clinic.

The stark contrast between working conditions for Mobile Clinic staff during MSF's management and post MSF's departure is understandably the source of much frustration among the health care providers. Research into non-state interventions has often pointed to the frustrations of state actors and the tensions that arise due to the involvement of non-state actors in local contexts (Kapilashrami & McPake, 2013; Kapilashrami & O'Brien, 2012), as well as the differential treatment of local staff from their expatriate counterparts (Pfeiffer, 2003; Redfield, 2012). In this case study, however, since MSF's departure, frustrations were around the inability of the programme to continue in the way it once had, and as such at the lack of support from the state to sustain it. Whilst the material differences in the support offered to the programme during MSF's involvement and since must not be overlooked, part of this frustration is also due to the different ways in which 'softer' issues were prioritised by MSF, but are not by the state. MSF prioritised team dynamic and well-being through workshops, supportive training, and building relationships with the DoH team. As such, energies and resources were redirected in ways which nurses felt were worthwhile and important. 'Softer' issues have not, however, been prioritised by the DoH. This resonates with work by McIntyre and Klugman (2003, p. 117) which highlights the missed opportunities of not prioritising 'health worker buy-in' and 'recognising and addressing health worker morale issues' within the public health care system in South Africa. The general lack of attention which is given to 'softer' issues within the South African public health system is also central to understanding the lack of workplace trust which Gilson and others have identified in this context (2003, 2006; Gilson, Palmer, & Schneider, 2005) and the difficulties in sustaining the programme. Conceptualisations of programme sustainability centre the importance of the integration of the programme in question into broader structures. For Schell et al. (2013), this is done through the extension of political and financial support to programme and planning. For Shigayeva and Coker (2015), this is achieved through the programme being at the nexus of a series of 'functional relationships', with fuller integration within these relationships lending itself to better sustainability. Trust itself 'is a relational notion' (Gilson, 2006, p. 360). As such, the lack of integration within 'functional relationships' between the local DoH and the DoH at District and Provincial levels points not only to why sustainability in this context is difficult, but also the source of discontent for mobile clinic staff. That being said, it must be recognised that state agencies, in particular those on the ground in Musina, were not consulted in the planning or inception of MSF's activities. Since these agencies have finite capacities and resources and competing demands placed on them, responding to initiatives that were not integrated from the outset with national-level planning, and therefore without allocated funds, pose a significant challenge and distinct burden on ongoing work. This echoes research by Cairney and Kapilashrami (2014) around the effects of PEPFAR and the Global Fund downscaling their activities in Namibia on the local Nambian health system. Authors illustrate how global health insitutions' demands of rapid scale-up were counterproductive to the sustainability of interventions and the human resources delivering care; and concerns around ownership and political will of state actors emerged only in the wake of a 'scale down' of donor funding to the Namibian health sector.

This case study raises two important questions. The first is about what it means to demonstrate an 'innovative' model of care if it does not secure the requisite buy-in from the state to sustain the innovation. Emergency humanitarian responses are, by their very nature, not expected to be sustainable, because the understanding is that an emergency is time bound and will come to an end. This intervention, however, like many of MSF's interventions in South Africa, sought to make long-term changes to the mechanisms through which migrant farm workers could access care, with a short-term time commitment from the organisation, and limited assurance that the state would commit to sustaining the intervention. In her assessment of iNGOs who provide funding, Younis raises important questions about 'the approach of relying on professional nongovernmental organisations (NGOs) that are funded from abroad for achieving social and political change' (2007, pp. 38, 39). She concludes that the reliance on non-local organisations for funding, and programmatic work in this case, can limit the long term efficacy and sustainability of change as funding may be difficult to replace once they leave. Berlan and Bruno-van Vijfeijken (2013) however argue instead that acknowledging that the interventions of non-local organisations are, by-and-large, 'time-bound' and planning for this may be a more sustainable model for iNGOs going forward. Their analysis suggests that planning for an organisation's inevitable departure lends itself to reliance on local actors and consequently the development of more sustainable programmes. However, as this case study shows, within this model the long term commitment of local state and non-state actors is relied upon, but that commitment cannot be assured.

Following on from this, the second question which this case study raises is about what it means to respond to the health of migrants in innovative ways which stem from a response to a 'crisis'. Vearey (2014) and Vearey et al. (2017) caution against the exceptionalisation of migrants through advocating for migration to be accounted for in general health systems, rather than ad hoc responses to particular migrants and their well-being. Given the way in which the Musina Model of Care (and other interventions which were not the focus of this paper) has fared, however, responses to migration and health in Musina remain bound to the 'crisis' of 2007/2008 and the involvement of iNGOs. Targetted responses to improve access to care for certain populations may be necessary. However, in the South African context, short-term initiatives, which exceptionalise such groups, undermine the state's constitutional commitment to the progressive realisation of access to quality and comprehensive health care for all, including migrants. At a global level, these kinds of interventions undermine commitments to and calls for integrated and people-centred health systems, including Universal Health Coverage. In order to uphold these commitments, it is important to develop policy and programmatic responses which acknowledge the realities of migration and mobility. As such, at the handover stage of interventions and programmes, from non-state to state actors, rather than simply focusing on administrative load, differences in priorities amongst stakeholders need to be interrogated.

As organisations like MSF move from more traditional aid interventions, to interventions where they 'demonstrate a model for some kind of service provision that's replicable and that [they are] able to hand over' (iNGO_01), understanding whether these interventions lend themselves to longer term structural change and are replicated by the state is important. In this case, five years since the departure of MSF from the area, remnants of the programme remain – importantly, ART is more accessible to farm workers than it was prior to MSF's involvement – as do fond memories of the time that MSF spent in Musina. However, the programme falls significantly short of closing the accessibility gap in health care for remote and migrant populations.

Notes

1. Responses varied, but this trip reportedly costs between 60 and 150 ZAR (5–12 USD).
2. Important to note is that, in accordance with the *Uniform Patient Free Schedule,* primary health care is free for all in South Africa, and as such all services provided by these two clinic programmes were (and are) provided free of charge.
3. Email correspondence with an MSF employee indicates that this cost the organisation 70,000 ZAR, 4991 USD at the time of writing.

4. The Office of the Premier plays an important role at a Provincial level in South Africa, working with the Provincial Premier and 'providing coherent strategic leadership and coordination in provincial policy formulation … and implementation' (The Presidency, 2008, p. 2).

Acknowledgements

We would like to thank all those who participated in this research, particularly those working with the mobile clinic programme in Musina. We would also like to thank Jo Vearey for her continued support and supervision of TdG, and Lenore Longwe for her administrative and logistical support during the research process.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the Wellcome Trust under Grant 04868/Z/14/Z, an Investigator Award held by Jo Vearey.

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6 Paper three – Responding to the health needs of migrant farm workers in South Africa: Opportunities and challenges for sustainable community-based responses

Paper three, which has been published with *Health and Social Care in the Community*, uses the two cadre of community-based healthcare worker trained on the farms around Musina as a case study through which to explore local responses to migration and health. The key finding at the centre of this paper is that community-based healthcare workers can form part of a sustainable, migration-aware response to health. However, the potential of such interventions is undermined by the timebound nature of the involvement of non-state actors, who primarily develop and implement these interventions, and the reluctance of the state to formally incorporate such cadre of workers into the healthcare system. As such, this paper also reflects on the timebound and localised nature of non-state interventions, and the crisis-bound and targeted nature of state interventions.

This paper uses data from key informant interviews, non-participant and participant observation, as well as data gathered from an analysis of policies around community-based healthcare workers in South Africa and grey literature pertaining to the implementation of such interventions.

An analysis of this data highlights how the sustainability of these programmes requires that the state (1) develop a consistent approach to remuneration that recognises the work done by these individuals, and (2) prioritise the software of these programmes – individuals often choose to become community-based healthcare workers in order to improve their skills, access opportunities, and/or (these reasons are not mutually exclusive) improve health and wellbeing within their communities. Such motivations need to be understood and used to improve the experiences of these workers within the programmes. As such, this paper sits within the literature discussed in sections 2.2 and 2.3 – *Health in South Africa* and *(un)Healthy Migration* respectively. Additionally, it builds on the discussion in (de Gruchy & Kapilashrami, 2019) [Paper Two], that points to the key role that workplace trust plays in the healthcare system. In Paper Two, the priority placed on the 'software' of the Musina Model of Care by MSF is in sharp contrast to the lack of interest in the software of the programme displayed by the DoH. This contrast emerges as a key frustration for

healthcare providers in the programme. In this paper, the importance of good working relationships between the various actors involved in the interventions, including the healthcare providers in the Musina Model of Care, the two cadre of community-based healthcare workers, and the farm workers is highlighted. As are the ways in which the bureaucratic inefficiencies of the state and the lack of a co-ordinated response to such programmes undermine these working relationships.

Finally, this paper brings to the fore ways in which the state relies on non-state intervention at particular moments. A key issue that is built upon in Paper Four and the Conclusion of this dissertation.

Received: 18 January 2019 | Revised: 24 May 2019 | Accepted: 7 August 2019

DOI: 10.1111/hsc.12840

ORIGINAL ARTICLE

Health and Social Care in the community

WILEY

Responding to the health needs of migrant farm workers in South Africa: Opportunities and challenges for sustainable community-based responses

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Funding information
This research was funded through a Wellcome Trust Grant 04868/Z/14/Z held by Jo Vearey.

Abstract

Reflecting global trends, migrant farm workers in South Africa experience challenges in accessing healthcare. On the commercial farms in Musina, a sub-district bordering Zimbabwe, Medécins sans Frontières and the International Organization for Migration both implemented migration-aware community-based programmes that included the training of community-based healthcare workers, to address these challenges. Using qualitative data, this paper explores the experiences that migrant farm workers, specifically those involved in the programmes, had of these interventions. A total of 79 semi-structured interviews were completed with migrant farm workers, farm managers, NGO employees and civil servants between January 2017 and July 2018. These data were supplemented by a review of grey and published literature, as well as observation and field notes. Findings indicate that participants were primarily positive about the interventions. However, since the departure of both Medécins sans Frontières and the International Organization for Migration, community members have struggled to sustain the projects and the structural differences between the two programmes have created tensions. This paper highlights the ways in which local interventions that mobilise community members can improve the access that rural, migrant farming communities have to healthcare. However, it simultaneously points to the ways in which these interventions are unsustainable given the realities of non-state interventions and the fragmented state approach to community-based healthcare workers. The findings presented in this paper support global calls for the inclusion of migration and health in government policy making at all levels. However, findings also capture the limitations of community-based interventions that do not recognise community-based healthcare workers as social actors and fail to take into account their motivations, desires and need for continued supervision. As such, ensuring that the ways in which migration and health are included in policy making are sustainable emerges as a necessary element to be included in global calls.

KEYWORDS
community health workers, community-based responses, migrant farm workers, migration and health, South Africa, sustainability

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1 | BACKGROUND

Recently, calls have been made at a global level for policies, at all levels of government, to be migration and health aware (Khan et al., 2016; Vearey, 2014; Wickramage & Annunziata, 2018). Research from the South African context has shown that local responses—or a lack thereof—can contribute to either exacerbating or mitigating the experiences that migrants have of accessing healthcare (Halogen & Vearey, 2010; Landau & Singh, 2008; Misago, 2016; Vearey, 2011).

One kind of local, community-based response to issues of health is programmes that train and equip community members to facilitate access to healthcare within the community. This approach has received renewed attention in South Africa, as well as in other low- and middle-income countries (LMICs), since the mid-1990s, as the under resourced South African public healthcare system is faced with multiple challenges in addressing the 'four colliding epidemics' of 'HIV and tuberculosis; chronic illness and mental health; injury and violence; and maternal, neonatal, and child health' (Mayosi et al., 2012; Nxumalo, Goudge, & Manderson, 2016; Schneider, Hlophe, & van Rensburg, 2008). However, although the state increasingly recognises the role that these programmes can play in addressing unmet health needs at the local level, policy responses have largely been fragmented and highlight that while the state sees these programmes and their cadres of workforce as important, they remain peripheral to the health system itself and their training and management is by-and-large left up to non-governmental organisations (NGOs) (Daniels, Clarke, & Ringsberg, 2012; van Ginneken, Lewin, & Berridge, 2010; Schneider et al., 2008). This reliance on external non-state actors has implications both for the sustainability of these programmes and for the security and well-being of these workers (Clarke, Dick, & Lewin, 2008; Nxumalo et al., 2016; Suri, Gan, & Carpenter, 2007). Additionally, it has also meant that there is little uniformity in the structure of these programmes (Friedman, 2005; Schneider et al., 2008).

For the purposes of this paper, these individuals will be referred to as community-based healthcare workers. However, within specific programmes they have different titles, varied responsibilities and levels of training, are sometimes volunteers and at other times are remunerated (Clarke et al., 2008; Friedman, 2005; Mwai et al., 2013).

This paper explores two programmatic interventions that independently developed cadres of community-based healthcare workers in order to improve the access that migrant farm workers in the area around the South African town of Musina had to healthcare. Ten kilometres from the Zimbabwean border, Musina has always seen the coming and going of Zimbabwean nationals, some of whom have traditionally found work, both seasonally and more permanently, on the farms surrounding the town (Bolt, 2016; Rutherford, 2008; Rutherford & Addison, 2007). In 2007 and 2008, in response to an increase in the number of Zimbabweans crossing the border to escape electoral violence and a cholera outbreak in Zimbabwe (Staff Reporter, 2008; Tran, 2008), several international organisations, including the International Organization for Migration (IOM) and Médecins sans Frontières (MSF), set up projects in the area. By 2009, this crisis had largely dissipated, and both organisations moved their focus to migrant farm workers on the commercial farms surrounding Musina, as vulnerable groups whose access to healthcare was limited and could be improved.

What is known about this topic

- Increasingly calls are being made for migration aware policies and programming at all levels of governance.
- In South Africa, health policies do not consider the realities of migration, which affects the access that migrants, including migrant farm workers, have to care.
- South Africa's approach to community-based interventions is fragmented and characterised by a reliance on non-state actors.

What this paper adds

- Original, empirical insights into community-based interventions, and their potential as migration-aware responses to health.
- An analysis of why community-based interventions are unsustainable in South Africa.
- Urgency to the call for sustainable migration aware policies and programmes.

Globally, while migrant farm workers are key to many commercial farming industries, more often than not structural barriers ensure that this workforce bears an undue burden of both communicable and non-communicable diseases (Arcury & Quandt, 2007; Rye & Andrzejewska, 2010). South Africa is no exception. While legislation 'covering rights to collective bargaining, basic conditions of employment, social security benefits and workplace health and safety' (London, 2003, p. 60) exist, the access that migrant farm workers have to these rights, including to healthcare, is limited. Subject to low wages and poor living and working conditions (Bolt, 2012; Jinnah, 2017; London, 2003), within a context in which the public health system is severely under resourced and programming is not migration-aware (Vearey, 2014, 2018; Vearey, Modisenyane, & Hunter-Adams, 2017), migrant farm workers are known to have one of the highest HIV prevalence rates in the country (International Organization for Migration, 2010).

In Musina, at the time that MSF and the IOM were developing programmes, the Department of Health had a mobile clinic programme that was meant to visit farm worker communities on rotation. However, it was severely under resourced and, importantly, unable to provide any form of HIV care or support. Furthermore, continuity of care for HIV—and other chronic conditions—has historically been very difficult in this area as patients move regularly and South African health systems are yet to respond to the realities of patient mobility, both cross-border and internal (Médecins

Sans Frontières, 2012, 2013; Vearey, 2014; Vearey et al., 2017). To address these gaps, MSF implemented the Musina Model of Care, an initiative that included a mobile clinic programme that provided voluntary counselling and testing (VCT) for HIV, antiretroviral therapy (ART) and developed a cadre of Community Health Workers (CHWs) to work alongside the clinic. In 2012, 10 CHWs were trained across 10 farms to work both with the mobile clinic and independently to test for malaria, support HIV treatment, run support groups and provide basic medical care within the farm compounds.

As MSF was developing and implementing its CHW programme, the IOM, working with the Centre for Positive Care (CPC) a local non-governmental organisation that acted as an implementing partner, trained on many of the same farms 103 farm workers as peer educators, referred to as Change Agents. This was part of the organisation's Ripfumelo project, a large-scale regional project which looked 'to reduce HIV and TB vulnerability amongst migrants and mobile populations and the communities affected by migration' across several areas in Southern Africa, including Musina. The primary difference between the two groups being that Change Agents educate and mobilise workers to seek care, while CHWs are able to provide some basic biomedical care.

Both of these interventions were envisaged as supporting the provision of biomedical care through the mobile clinic. At the height of the interventions' success, CHWs and Change Agents were part of a robust migration-aware response to the intricacies of healthcare access for this group of workers. However, neither MSF nor IOM could commit to sustaining the programmes for more than a few years. MSF had hoped that when they left the CHWs would be incorporated into the Department of Health. However, at the time of MSF's exit, the Department argued that it was not able to take over the cost and the maintenance of the programme. As such, the programme was managed and funded by North Star Alliance, an international NGO that provides health services to mobile workers, for a year, after which it was handed over to the CPC, this time as an implementing partner of the Department of Health. CPC, at this time, remained an implementing partner of the IOM and involved in the training and management of Change Agents. At the end of 2017, the IOM brought an end to its migration and health related activities in the area, including funding for CPC. CPC have consequently left the area, handing the management of the CHW programme over to the local branch of a humanitarian organisation in the area, but leaving no provision for the Change Agents (see Figure 1 for a timeline of these two programmes).

This paper is based on research conducted as part of a broader project that has examined the role that non-state actors have played in responding to migration and health in South Africa, and the longer term implications of their involvement with migrant farm workers around Musina (see Author and others, 2019). Key issues on which the research reflects have included the nature of responses by both state and non-state actors to migration and health. This paper uses the CHWs and Change Agents to illustrate the ways in which such workers can form part of a sustainable, migration aware response to health. But the paper also demonstrates how this is undermined by both the timebound nature of non-state interventions and the state's reluctance to incorporate community-based healthcare workers more formally within the health system.

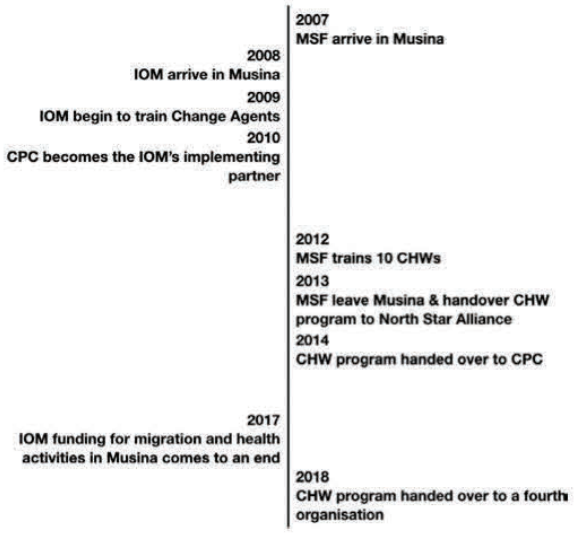

FIGURE 1 Timeline of the Change Agent and Community Health Worker programmes

2 | MATERIALS AND METHODS

Several qualitative methods were used in this research, including key informant interviews, an analysis of grey literature and observation of the mobile clinic programme.

2.1 | Key informant interviews

A total of 79 in-depth, key informant interviews were conducted, the specifics of which can be found in Table 1.

To understand workers' experiences of the interventions, interviews were conducted across two farms on which the interventions had been implemented and where farm management were willing for researchers to conduct interviews during work hours. Most of these interviews were conducted by two research assistants who had received training on conducting interviews with farm workers, and the ethics thereof, and were able to conduct interviews in ChiShona, the language of choice for many of the farm workers. Audio recordings of interviews that were conducted in ChiShona were sent to a translator, who both translated and transcribed the interviews into English for analysis by the author.

Individuals were approached as they stopped work for lunch, waited for the mobile clinic to set up or leave, or were introduced to the researchers by others who had already been interviewed. Informed consent was sought prior to interviews commencing. Interviewees were asked to provide either written or verbal consent

TABLE 1 Details of key informant interviews

Interviews conducted with	Number of interviews conducted
Agricultural sector organisations	
1 female	5
1 group (mixed)	
3 males	
Change agents	
2 females	11
2 groups (mixed)	
7 males	
Civil servants (excluding DoH Musina)	
1 female	5
1 group (mixed)	
3 males	
Community Health Workers (CHWs)	
3 females	3
Farm management	
1 female	5
2 group (mixed)	
2 males	
Farm workers	
18 females	32
1 group (all female)	
13 males	
Non-governmental organisations (local and international)	
6 females	11
5 males	
Mobile clinic staff	
3 females	4
1 group (mixed)	
Other	
2 females	3
1 group (all male)	
Total	
37 females	79
9 groups	
33 males	

to being interviewed, as well as their consent to the use of a voice recorder. Of the farm workers, including Change Agents, interviewed, only two were South African. The remaining 41 were Zimbabwean nationals. Group interviews were conducted where the initial interviewee contacted indicated that their colleague would have information or insights of relevance.

Data from interviews was thematically analysed using Dedoose 8.2.14. 74 codes were identified through the initial analysis of the data, and these were then examined in relation to one another as themes.

2.2 | Observation

It proved challenging to formally interview many of the Department of Health employed healthcare professionals who work on the mobile clinic given the constraints of their work. As such, observation of the mobile clinic was undertaken between May and July 2017. Time was spent in the mobile clinic offices (specifically in the morning as the nurses prepared to leave for the day), travelling with the mobile clinics and observing how the healthcare workers related to workers when they arrived on the farms. Observations and informal conversations were recorded as field notes, which were subsequently thematically analysed. No treatment or care itself was observed.

2.3 | Grey literature

In addition, to supplement a review of published literature, a thematic analysis of 76 documents—including policy directives, meeting minutes, memos, project reports, policy documents and emails relating to the projects—was undertaken. By-and-large, these documents were collected as interviews took place and participants indicated that a particular document might be of interest or use. Documents were thematically analysed in conjunction with interview data to triangulate information and provide details that may have been forgotten by participants. Use of these data were limited however, as key informants had to be relied upon to send the author documents that they had deemed sufficiently relevant to keep.

The details of this study were reviewed and approved by the University of the Witwatersrand Non-Medical Research Ethics Committee (REC). Ethical clearance was given under protocol H16/08/10.

3 | RESULTS

In this section, the two programmes are presented together to highlight their differences, as well as the ways in which the two workforces interacted and continue to interact against a fragmented policy and programmatic landscape.

3.1 | Improving access to care

While the two groups were conceptualised and trained as different kinds of community-based healthcare workers, central to both programmes was the expectation that these interventions would improve the knowledge of and access to healthcare that migrant farm workers had.

As MSF's hope had been that the CHWs would be incorporated into the Department of Health when MSF left, the original cohort of CHWs trained by MSF were trained using accredited state curricula for lay HIV counsellors (iNGO_06). However, since MSF has left, the training of CHWs has become ad hoc. None of the CHWs interviewed as part of this research were part of the original cohort

of MSF-trained CHWs, and none indicated having undergone state accredited training.

The experiences of the CHW programme are in some respects similar across both farms; CHWs are regarded as important sources of care and expertise, specifically around HIV/AIDS. As one farm worker indicated:

> The Community Health Worker advises people that, if you [have] been found to be with these diseases (HIV and AIDS) this does not mean that you no longer have life, but that you are able to live life after contracting this disease. The Community Health Worker also advises people that if you have contracted this disease, you must take your treatment in a proper way advised for you to live longer.
>
> (MFW_LM_101)

The Change Agents, on the other hand, were trained to act as community leaders, facilitate dialogue, educate farm workers on issues of healthcare, dispense condoms, and plan weekend activities so 'that farm workers use their free time in sports rather than engaging in unprotected sexual activities and abusing alcohol and drugs' (IOM_10). Given this broader range of potential roles that Change Agents could and can play, these individuals are not exclusively regarded as healthcare workers by community members.

Most farm workers interviewed reported positive experiences of both CHWs and Change Agents, and importantly that they know who these individuals are and the work that they do. However, across the two farms, three farm workers reported that they would only be able to identify the CHW by face, rather than by name, and three reported that they were unaware of the CHW. While these are not large numbers, they do highlight the limitations of community-based workers: even within a confined farm there are those farm workers who, for whatever reason, are beyond the CHW's reach.

3.2 | Motivations and status

While the experiences that farm workers had of the CHWs and Change Agents are important, the experiences that these individuals had and have of being part of the programmes and of trying to fulfil their roles in the wake of MSF and the IOM's departures emerged as a central theme in this research.

Part of the initial success of the Change Agent programme can be attributed to the fact that workers saw the process of becoming a Change Agent as personally beneficial. Primarily it appears that the opportunity to be trained and receive a certificate to such effect fitted within what individuals saw as their broader life trajectories and created a sense of purpose outside of their work on the farm:

> As for me, I decided to be a Change Agent because I was a person who had a course for teaching people about life and how people should manage themselves, whilst at the same time being very careful in safeguarding their lives as well as issues that are related to hygiene … Plus, at that time, there were many diseases at this farm and people (farm workers) were also being (sexually) abused (by senior employees).
>
> (CA_EG_101)

In addition, both CHWs and Change Agents have an elevated status within the compound and farm as a result of their involvement in the programmes. CHWs, in particular, have currency with figures of authority, as one reflects:

> When I fall sick, I call the ambulance. I have the telephone numbers for the ambulance. So, I call them by saying to them, please I am sick here. I am not feeling well. My illness will also worry the ambulance people as they will say, among themselves 'oh no, our CHW has fallen sick'. They will then come to me and attend me … Even the police, they know about us. If we have a problem concerning the police, I call the police directly, myself … Even the white people (farm management) here, know that, if they see me among workers in the farm fields, they know what my duties are, among their workers.
>
> (CHW_03)

As noted here, CHWs in the area and state service providers, including mobile clinic staff, developed a good working relationship, which—at the time of writing in May 2019—continues to facilitate the access that farm workers have to care. Reflecting on the importance of CHWs for the mobile clinic, one nurse explained:

> Most of the time when you go there, you're trying to trace the patient, no one knows the patient. At least if you have the CHW, they'll look for them, they'll track the patient for us, because they stay there and know everyone. Even if someone is sick, they're there and to call the ambulance … maybe there's something during the week and we didn't go, we contact them, the CHW people there … we call them and say 'we cannot make it on this day, but we can come on this date'.
>
> (DoH_02)

Similarly, through the programme, a relationship was established between the Change Agents and the mobile clinic staff. Like the CHWs, they are able to contact emergency medical services and are now able to advise workers what services the mobile clinic is able to provide. In addition, sporting events and drama groups organised by the Change Agents have also been used as opportunities for the mobile clinic to visit and provide voluntary counselling and testing (VCT).

Across the two farms there is however one salient difference in the CHW's role and status. On one of the farms, the CHW is very clearly regarded as an important part of farm life. She grew up on the farm and is married to the head Change Agent (and in some interviews quite explicitly referred to as 'The wife of Sizwe' (pseudonym)), who is a senior employee and has a closer relationship with farm management than many of the other workers. In one interview referred to by a farm worker as 'our leader' (MFW_EG_103), she is very present on the farm and the lives of the workers, describing herself as motivated to fulfil her role as CHW, 'a full-time job'.

On the second farm, however, the importance of the role of the CHW is acknowledged, but the CHW is regarded with some frustration and irritation, as she is often absent from the farm:

> The problem that we have is that, she cannot be found easily … If you are lucky to find her, she can help you.
> (MFW_EG_201)

The role that this CHW plays on this farm is markedly different from the previous example. Here, the CHW indicates that while she has a room on the farm, this is not her home, and her role is to be present every second week—coinciding with the mobile clinic visits. When interviewed, this CHW often deferred to Change Agents and indicated that, in her opinion, the role of the CHW and Change Agents is 'the same' (CHW_02). Unlike the CHW on the first farm, there is little indication that she feels particularly motivated or invested in her role and life on the farm. As a reflection of this, when farm workers on this farm were asked about the CHW, they often referred to one of the Change Agents. Here Change Agents were more heavily relied upon, in some instances to fulfil the duties of the CHW:

> the Change Agents that I had known of, they used to do this, if a person is injured at the soccer match, they would somehow put a bandage on this injured person or give this person anything that they had, that could stop the pain. I have not yet seen this being done by a community health worker. What I have seen is, the Community Health Worker, shouting in the compound saying, we have the mobile clinic today, please come. This is what I have seen happening in this compound.
> (MFW_LM_204)

3.3 | Frustrations and insecurity

The frustrations expressed in relation to the CHW on the second farm are part of a broader set of frustrations that both Change Agents and CHWs expressed during the research.

Although the Change Agents continue to have some status within the community, the benefits that the Change Agents derive from their volunteerism have been limited by the exit of the IOM and the CPC from the area. The IOM clearly imagined the Change Agents as being self-sufficient upon their exit. However, without external support, many Change Agents are despondent and frustrated by their responsibilities. The general inability of the Change Agents to organise activities that were once part of compound life is a source of frustration, and seen as a direct consequence of the IOM and the CPC no longer having funding:

> We used to have about ten teams. I used to have meetings … I used to be given soccer balls … Right now, I am not able to get these things because I am no longer in contact with [CPC employee]. [He] as an individual, I sometimes get hold of him, but he no longer has contact with those sponsors who used to sponsor him, and now, he has nothing to give us.
> (CA_EG_201)

This frustration spills over into resentment over the lack of more formal recognition of their work. While Change Agents acknowledge that they signed up as volunteers, the apparent promise of compensation at some future point appears to have been a motivating factor. CPC, for their part, acknowledge this expectation, but express the view that Change Agents should have become formalised within and compensated through farm structures, although there is no evidence that this was ever discussed with farm management.

However, while CHWs are remunerated for their work, they remain financially insecure. CHWs are paid their monthly stipend through whichever organisation is acting as the state's implementing partner at the time. However, contracts between the state and these NGOs need to be renewed annually. Regular delays in this process lead to delays in the payment of CHW stipends. For example, in 2017, the CHWs around Musina were not paid until July as CPC waited for their contract with the Department of Health to be renewed. In addition, following MSF's departure in 2013, there appears to have been very little follow-up or consistent support and supervision from the organisations that have managed the programme. Although the CPC, for example, claims to have visited the farms regularly, and expected monthly reports directly from the CHWs, reports indicate that the organisation did not visit the farms at all during the last year (2017) of their time in Musina. In July 2018, research participants indicated that the organisation now managing the programme have yet to engage with the CHWs.

Regardless of this lack of support and the irregularities around remuneration, however, the fact that CHWs are remunerated while Change Agents are not has become a source of tension on the second farm:

> She (the CHW) is earning, but I do not know how much. We are not allowed to give people medicines, but we are allowed to test people. She tests people and we also test people; this is where we do the same thing. However, she is the one who provides us with the testing equipment. The other difference is that, [she] as a community health worker, she is paid. She is earning, but I do not know how much money is it …

> at this farm, we have not yet been paid but we hear through rumours, that on other farms … the rumours are saying that, the volunteers are earning. They are not paid monthly or annually, but these people are happy to attend the meetings because, at times, they are given R600 or R1000 (between $42–$70 at the time of writing) per volunteer. But as for us, we have not yet received anything!
>
> (CA_EG_203)

The structural differences in the programmes, specifically around remuneration, pose a barrier to the two cadre of workforce happily co-existing. When additional social factors exist, as on the first farm, this barrier is overcome. However, in the absence of these factors, as on the second farm, tension is a reality.

4 | DISCUSSION

This paper fits within the broader literature in South Africa, as well as other LMIC contexts, about the sustainability of community-based health worker programmes.

What these two examples show is that such programmes have the potential to be migration aware; within migrant communities, community-based healthcare workers can be migrants themselves and training can include awareness about migration as a determinant of health (Vearey et al., 2017). In addition, regardless of their migrant status, workers enthusiastically took part in these programmes and, by-and-large, felt that the programmes had positively affected the health and well-being of their community. However, the sustainability of the programmes has been undermined as, reflecting much of the literature, the key 'software' underpinning the efficacy of these cadre of workforce—motivation and supervision—as well as their integration within the broader health system have been neglected by the state (Gilson, 2006; Kok et al., 2017; Sheikh, George, & Gilson, 2014).

While the disparity in financial remuneration between the CHWs and the Change Agents emerged as a key tension in this case, both the research presented here, and the literature highlight that financial remuneration is not the sole motivation that individuals have for becoming community-based healthcare workers (Akintola, 2011; Greenspan et al., 2013; Kidman, Nice, Taylor, & Thurman, 2014; Mwai et al., 2013; Pallas et al., 2013). A desire to learn, as well as to improve the lives of loved ones and the general health and well-being of the community, are also key factors that motivate individuals to participate in such programmes. However, as Greenspan et al note (Greenspan et al., 2013), a 'strong volunteer spirit … does not preclude a desire for financial rewards'. As many CHWs and Change Agents saw these programmes as an opportunity to up-skill and improve their status within the community, the lack of continued engagement by and support from external actors is keenly felt. This echoes findings by Akintola (2011) and Suri *et al.*, with the latter highlighting the importance of supervisors and supervision in such programmes:

> For community-based programs to be successful, issues of sustainability must be addressed. Specific attention should be paid to the motivation of CHWs, such as those relating to cross-sector resentment, individual financial stresses, and lack of emotional support. CHW program supervisors and administrators must consider the full gamut of motivating and demotivating factors in planning ongoing support.'
>
> (2007)

The lack of supervision and integration of the programmes within the broader state healthcare system are two additional factors that undermine the sustainability of these programmes. Supervision and integration have both been identified as key enabling factors or barriers to the sustainability of community-based programmes (Assegaai & Schneider, 2019; Mwai et al., 2013; Pallas et al., 2013). Kok et al. (2017) argue that community-based workers need to be seen as 'social actors'; that trusting relationships with both the communities that they serve and the healthcare system are pivotal to their efficacy and sustainability. The role that the former plays is illustrated here by the different responses to the CHWs on the two farms, which also highlight the importance of 'community fit' for sustainability (Pallas et al., 2013) and perhaps the lack of care that was given to 'community fit' in the selection of the CHW on the second farm.

Gilson and others highlight the importance of 'workplace trust' in health systems (Gilson, 2006; Gilson, Palmer, & Schneider, 2005). This research indicates that community-based healthcare workers can have a good working relationship and trust one part of the health system, in this case the mobile clinic staff and local emergency medical services, while simultaneously not being integrated into or trusting the broader structures of the health system. Research on the relationship between community-based healthcare workers who are able to provide some biomedical care and nurses indicates that nurses often feel threated by these workers and are prone to enforcing professional hierarchies in counter-productive ways when forced to work together (van Ginneken et al., 2010; Schneider et al., 2008). The good working relationship between the CHWs and nurses documented here contradicts much of this. This may be because in this case CHWs are isolated on the farms, and, as such, have a very clearly demarcated role—providing support and care to farm workers between mobile clinic visits. Consequently, they are of no direct threat to the nurses who leave the farm after each visit. Regardless, trust in the broader health system is limited, and may in fact be compounded by the fact that mobile clinic staff themselves indicate little trust in the broader Department of Health, the nuances of which are described in de Gruchy and Kapilashrami (2019).

Finally, theories of sustainability point to the importance of integrating interventions into broader structures (Schell et al., 2013; Shigayeva & Coker, 2015). Here, implementing organisations were unable to secure this integration prior to their departure, due to the state's fragmented interest in and response to such interventions, characterised by a lack of sufficient attention to or support for this workforce (Daniels et al., 2012; van Ginneken et al., 2010; Schneider et al., 2008).

This paper shows how community-based healthcare workers can, and do, play an important role in health systems. However, as it makes clear, within the South African system, the fragmented approach to these workers undermines this potential.

The findings from this research support the call for migration and health to be prioritised within policy and programmatic responses to well-being (Vearey, 2018; Vearey et al., 2017; Wickramage & Annunziata, 2018), and highlight the role that community-based healthcare workers can play within this. However, it raises important questions about the development of these cadre of workforce within a context in which factors enabling their sustainability are limited. As such, ensuring that the ways in which migration and health are included in policy making are sustainable emerges as a necessary element to be included in global calls.

ACKNOWLEDGEMENTS

The author thank all who agreed to participant in this research, in particular both current and former employees of Médecins sans Frontières, the International Organization for Migration, the Centre for Positive Care, and the South African Department of Health. In addition, Jo Vearey and Anuj Kapilashrami are thanked for their supervision and support, and Lenore Longwe for her administrative support during the research. This research was funded through a Wellcome Trust Grant 04868/Z/14/Z held by Jo Vearey.

CONFLICT OF INTEREST

There are no conflicts of interest to be declared.

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How to cite this article: de Gruchy T. Responding to the health needs of migrant farm workers in South Africa: Opportunities and challenges for sustainable community-based responses. *Health Soc Care Community*. 2019;00:1–9. https://doi.org/10.1111/hsc.12840

7 Paper four – Sustainability & the state: Towards an improved understanding of policy processes, a case study of migration & health in South Africa

This single-authored paper, which has been submitted to *Critical Social Policy*, uses the preceding three papers as the building blocks to develop a conceptual understanding of the policy and governance processes that this research investigated. As such, it draws on all four of the key findings that emerged from this research, but focuses in particular on the governance elements to these themes. Rather than being an empirical paper, it develops a more conceptual argument in response to my research question, which positions this PhD in relation to the lack of locally relevant policy frameworks, and the limited nature of both research on and responses to migration and health. Consequently, this paper explores what a conceptual framework to improve understandings of policy processes around migration and health in South Africa would look like. It uses the case study of the responses to the health and wellbeing of migrant farm workers in Musina, built through papers one, two, and three to articulate a response to three of my research objectives:

1. To understand how policies on issues of migration and health are framed in South Africa;
2. To investigate the development of policy and programmatic responses to migration and health in South Africa, from agenda setting to implementation, and experiences thereof; and
3. To be able to explain, conceptually, why policies are made or left un-made, and in so doing address the limitations of existing frameworks.

While these have been responded to implicitly through the three empirical papers, responses to each of these objectives are more explicitly formulated here. The framing of the access that migrants have to healthcare is shown to be either in relation to migrants as a burden on the public health system or in relation to a 'crisis' necessitating a humanitarian response. While the policy process initiated by the involvement of external actors is shown to be a short-term diversion for the state.

This paper uses existing theories and frameworks in an attempt to make conceptual sense of these findings. It brings to the fore the tensions between the empirical data,

highlighted throughout papers one, two, and three, and this literature. This paper argues that while the temporal element that elucidates a policy change is captured in existing theories and frameworks, the temporal element to their sustainability is ignored. In terms of improving responses to migration and health in general, and the health of migrant farm workers specifically, understandings of sustainability and the mechanisms that are or are not developed to ensure and improve the sustainability of responses need to be improved. As such, the paper concludes by providing an alternative conceptualisation of the policy process in a context characterised by a reactive state and the involvement of iNGOs.

Re: CSP article 1867

3 messages

CSP Articles <articlescsp@gmail.com> 4 September 2019 at 19:43
To: Thea de Gruchy <theadegruchy@gmail.com>

Dear Thea,
Thank you for submitting your article to Critical Social Policy and I can confirm that it fulfils our initial requirements.

Your article will now be considered at our next Editorial Board meeting in October and you should have a response within 2-3 weeks after this date. Before then it will be read anonymously by three referees and there are four possible outcomes: publish; publish/edit; not publish; and rewrite.

The first three are self explanatory and the convenor for your article will write to you to inform you of the outcome. In terms of rewrite, we do not guarantee publication of the re-written article but the article will be refereed again.

Thank you for considering Critical Social Policy and if you have any queries at all in the meantime, please get in touch with me, quoting your article's reference number 1867.

I attach a copy in the form in which it will be sent out for review.

With best wishes,

Patricia Ladly
Patricia Ladly
Journal Administrator

On Wed, 4 Sep 2019 at 14:49, Thea de Gruchy <theadegruchy@gmail.com> wrote:

> To whomever it may concern,
>
> I'd like to submit the attached article, titled *Sustainability and the state: Towards an improved understanding of policy processes, a case study of migration and health in South Africa*, for consideration by *Critical Social Policy*.
>
> The attached manuscript has been anonymised and is been accompanied by a cover letter.
>
> Please let me know if you require any additional documentation or information.
>
> Regards,
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Thea de Gruchy <theadegruchy@gmail.com> 5 September 2019 at 09:32

CSP ARTICLE 1867 **5.9.19**

Sustainability & the state: Towards an improved understanding of policy processes, a case study of migration and health in South Africa

Abstract
Globally efforts are being made to curtail healthcare access for cross-border migrants. In South Africa, for example, the recent National Health Insurance Bill proposes a drastic reduction in services to which migrants are currently entitled. This is within a broader context in which attempts to engage with cross-border migration are increasing securitised and xenophobic, placing migrants in precarious positions and limiting access to, among other things, the public health system. Consequently, improving understandings of how policies that address issues of migration and health are developed and implemented is imperative. Using a case study of interventions to improve the health of migrant farm workers along the South African border with Zimbabwe, this paper unpacks the tensions between this empirical data and theories of policy process. In response, it proposes an alternative approach that takes into account the presence of international organisations and the importance of sustainability within low- and middle-income countries.

Keywords Policy, Humanitarianism , Migrant farm workers, Development, Low- and middle-income countries

Introduction

Policies, defined here as anything that 'involves the decision (including both actions and nonactions (sic)) of a government or an equivalent authority' (Sabatier and Weible, 2014: 4), that aim to engage with, specifically 'tackle' or 'curb', cross-border migration often fail to meet this outcome (Castles, 2004, 2017; Scholten, 2019).

As Cornelius, Martin and Hollifield argue:

> The gap between the *goals* of national immigration policy ... and the actual results of policies in this area (policy *outcomes*) is wide and growing wider in all major industrialised democracies. (Cornelius, Martin and Hollifield 1994 in Castles, 2004)

Understanding this 'failure', particularly as it continues to engineer ways for economic growth in receiving communities and countries, has long been a source of interest for researchers … However, in South Africa, as in other low- and middle-income countries (LMICs), understanding this 'failure' has been hampered by the fact that many theories of policy process – 'the interactions over time between public policy and its surrounding actors, events, and contexts, as well as the policy or policies' outcomes (Sabatier and Weible, 2014: 5) – have been developed in and for high-income countries (HICs), specifically in North America and Europe (Jenkins-Smith et al., 2014; Nwalie, 2019; Pierce, Peterson, Jones, et al., 2017). One example of this is the Advocacy Coalition Framework (ACF). While a key theory that 'models public policy as a conflict between actors competing to translate their beliefs into policy' (Pierce, Peterson and Hicks, 2017: 2) and although recent work has argued that this need not be the case (Nwalie, 2019: 18), the ACF's application, development, and efficacy has primarily taken place in the global North (Jenkins-Smith et al., 2014; Nwalie, 2019; Pierce, Peterson, Jones, et al., 2017).

Research in LMICs has instead favoured the use of frameworks, specifically the 3 I's (Gauvin, 2014) and Walt and Gilson's framework for analysis (Walt and Gilson, 1994). Both of these operate largely as 'theoretical checklist(s)' (Gauvin, 2014) – pointing the researcher in the direction of the key components necessarily to elicit policy change. In the case of the former – ideas, institutions, and interests have guided work on health (Shearer et al., 2016); trafficking (Palmary et al., 2018; Palmary and de Gruchy, 2016); and policy responses to migrant domestic workers (Ashraf, 2016; Koh et al., 2017). While the latter has been widely used across LMICs, although this has primarily been within work on the health sector (Agyepong and Adjei, 2007; Gilson and Raphaely, 2008; Shiffman and Smith, 2007).

Given the various ways in which policies relating to migration are deployed globally, there is an imperative to improve our understanding of the processes through which

they are developed, implemented, and, as I will argue, sustained, specifically in instances where positive outcomes are seen. In South Africa, reflecting trends seen elsewhere (Carballo et al., 2017; Cuadra, 2012), migrants are both actively excluded from accessing services and have limited access to social determinants that would positively affect their health and well-being, including the health system. This is due to a lack of migration-aware and mobility-competent policies and programming in which 'population movement (and health) is embedded as a central concern in the design of health interventions, policy, and research' (Vearey et al., 2017: 90).

The South African public health system, on which the majority of the population rely - and with which this paper is concerned - is overburdened, under resourced, and faced with the 'four colliding epidemics' of HIV and tuberculosis (TB); injury and violence; chronic illness and mental health; and maternal, neonatal, and child health (Mayosi et al., 2012). 'The epicentre of the HIV pandemic' (Allinder and Fleischman, 2019), policies and programming in South Africa have failed to take into account the realities of both cross-border and internal migration and mobility, with severe consequences for migrant and mobile communities (Camlin et al., 2018; Tanser et al., 2015; Vearey, 2018; Vearey et al., 2017). As such, migrant and mobile communities, have emerged as key populations 'left behind' as South Africa attempts to meet its commitments to Universal Health Coverage (UHC), as one of the Sustainable Development Goals (SDGs) (3.8), and global HIV targets, including UNAIDS 90:90:90[ii] (de Gruchy & Vearey, forthcoming).

One such community of migrants who have traditionally been 'left behind' by health policies and programming are migrant farm workers living and working on commercial farms along the South African border with Zimbabwe. This community have limited access to positive social determinants of health as a result of their social and geographic isolation, the poor material circumstances in which they find themselves, the poor implementation of labour legislation in this sector, the fragmented and siloed

approach of the state to the sector and these workers, and the inaccessibility of the health system to this population (de Gruchy and Vearey, forthcoming). One of the outcomes of this has been that this community has a disproportionate burden of HIV. In 2010, prevalence of HIV among this community was 28.1%, almost double that of Vhembe District (14.7%), within which the farms are situated (International Organization for Migration, 2010: 9).

However, as I go on to explain, several interventions were specifically developed by non-state actors to improve the access that this population had to healthcare in general, but HIV care and treatment specifically. The development and implementation of these programmes within the broader South African context provides an excellent vantage point through which to investigate policy and programmatic responses to migration and health, as well as the development, implementation, and sustainability of such responses.

Research context & Musina case study

The empirical data from this research has been explored in-depth across three publications (de Gruchy, 2019; de Gruchy and Kapilashrami, 2019; de Gruchy and Vearey, forthcoming). As such, while a brief overview of the context and findings will be given, I will highlight the points at which more information and a deeper analysis can be found in the accompanying articles.

Given its location along the South Africa-Zimbabwe border, Musina, a municipality of Vhembe District, has a large cross-border migrant population. Between 2007 and 2008, due to electoral violence, economic breakdown, and a cholera epidemic, an increased number of Zimbabweans crossed the border converging on the town of Musina (Rondganger, 2008; Staff Reporter, 2008; Vearey and Anderson, Unpublished). In December 2008, Vhembe itself was declared a disaster area as the cholera epidemic crossed the Limpopo River. In order to both assist the struggling municipality and encourage the development of appropriate responses to cross-border migration in

the area, international organisations, including Médecins sans Frontières (MSF) and the International Organization for Migration (IOM), moved into Musina (Vearey & Anderson, Unpublished).

Once the initial crisis had passed, organisations turned their attention to vulnerable groups in the area, specifically those 'left behind' by the lack of migration-aware and mobility-competent state health policies and programming (de Gruchy and Vearey, forthcoming). One such community was migrant farm workers living and working on approximately 60 commercial farms in the Municipality (Médecins Sans Frontières, 2012). While the context within which migrant farm workers find themselves in Musina is, in many ways, unique, it also fits within a broader context within which the access that farm workers have to healthcare, as well as other social and political rights, is limited across South Africa. Farm workers across South Africa have, in general, poor health outcomes, including a disproportionate burden of HIV (International Organization for Migration, 2010; Kruger et al., 2006; London, 2003). Health and safety legislation and standards for export are insufficiently concerned with the well-being of workers (Bain, 2010; London, 1998). In addition, labour legislation is poorly implemented in this sector where wages are low and workers often live on farms in accommodation provided by farmers (Devereux, 2019; Lemke and Jansen van Rensburg, 2014; Visser and Ferrer, 2015; Wisborg et al., 2013)

In 2009, in recognition of the burden of disease within this community and the poor access that migrant farm workers had to social determinants that could positively affect their health (de Gruchy and Vearey, forthcoming), MSF launched the Musina Model of Care. This programme was designed to provide HIV care and treatment to this mobile community (Médecins Sans Frontières, 2012). As such, it consisted of a mobile clinic that would visit ten farms, providing Voluntary Counselling and Testing for HIV (VCT) and Antiretroviral Therapy (ART) to farm workers. In addition, ten members of the farm worker community were trained by MSF as Community Health Workers to provide community-based support and basic health care, and act as a link

between the workers and the mobile clinic (de Gruchy, 2019; de Gruchy and Kapilashrami, 2019; Médecins Sans Frontières, 2012, 2013).

Simultaneously, the IOM, working with a local non-governmental organisation as their implementing partner, trained a cadre of over a hundred volunteer peer educators, referred to as Change Agents, across several farms to facilitate dialogue and raise awareness about issues of concern within the compounds, specifically around issues of health and gender-based violence (de Gruchy, 2019). In addition, in collaboration with the Vhembe District administration, the IOM established the Vhembe District Migrant Health Forum (VDMHF), an intersectoral forum that local and international organisations, government departments, and individuals concerned with issues around migration and health could attend and use to trouble shoot their concerns, in 2009.

The interventions in Musina are three of a very small number of programmes that have specifically looked at improving the access that migrant farm workers have to health care. However, while initially all three were described as successful, their sustainability is in question. In 2013, MSF left Musina, handing the management of the Musina Model of Care over to the Department of Health (DoH) (de Gruchy and Kapilashrami, 2019). While in 2017, the IOM brought an end to their health programming in the area, and with it support for the Change Agents, who have been left to their own devices (de Gruchy, 2019), and the VDMHF, for which the District agreed to take responsibility.

Given this context, Musina provides an interesting case study through which to investigate the processes that led to the development of responses to migration and health, and the associated challenges and opportunities.

Methods

This paper draws on four key findings from the data that formed the basis of the three accompanying publications (de Gruchy, 2019; de Gruchy and Kapilashrami, 2019; de Gruchy and Vearey, forthcoming). As such, the primary method used in the writing of

this paper has been the identification and review of published literature around policy process, specifically, where it could be found, in relation to policies around issues of migration and health. Key policy frameworks and theories with which I engaged included Sabatier's Advocacy Coalition Framework (ACF) (Jenkins-Smith et al., 2014; Sabatier, 1991), Kingdon's Multiple Streams Approach (Béland, 2016; Kingdon, 2001, 2011), Walt and Gilson's model for analysis, which centres content, context, process, and actors (Walt et al., 2008; Walt and Gilson, 1994), and the 3 I's framework (Gauvin, 2014; Shearer et al., 2016). These have been read through the thematic analysis of the empirical data.

In brief, the empirical data was collected through:

1. An analysis of grey literature – both policy documents regarding migration and health at global, regional, and national levels of governance, as well as meeting minutes, reports, and memos that pertained to the Musina Model of Care, Change Agents, and VDMHF;
2. 79 key informant interviews (see Table 1 for details);
3. Participant observation of the VDMHF and several other fora and events between 2015 and 2018; and
4. Non-participant observation of the mobile clinic programme. No treatment or care itself was observed.

Table 1: Key informant interviews

	Number of interviews conducted
Agricultural sector organisations	5
Change agents	11
Civil servants (not DoH local)	5
Community Health Workers	3
Farm management	5

Farm workers	32
International organisations - IOM, MSF, PEPFAR	7
Local NGOs	4
Mobile clinic staff	4
Private companies	2
South African Local Government Association (SALGA)	1
	79

Ethical clearance was obtained from the University of the Witwatersrand Non-Medical Research Ethics Committee (REC), protocol H16/08/10.

Analysis & findings

A thematic analysis of the empirical data highlighted several central features to the development of the interventions, some of which concepts and mechanisms from theories of policy change are able to explain at a conceptual level, while others emerge in tension to these theories and frameworks.

The first key feature of the process captured through the research relates to the temporal aspect of responses to migration and health. While research has long pointed to the disproportionate burden of disease borne by migrant farm workers (International Organization for Migration, 2010; London, 2003; de Gruchy and Vearey, forthcoming), responses to migration and health in general, and efforts to improve the health and well-being of migrant farm workers in particular, have long been lacking (Camlin et al., 2018; Vearey, 2018; Vearey et al., 2017). As such, although migrant farm workers have lived and worked on the farms around Musina for several decades (Bolt, 2016; Rutherford and Addison, 2007), it was only with the 'crisis' created by the increase in the number of Zimbabweans moving across the border in 2007/08 and the subsequent cholera outbreak in Musina that the social and political will, as well as the

material resources from both state and non-state actors, came together to elicit a response to migration and health in the area.

This 'crisis' created, what the Multiple Streams Approach terms, a 'policy window' – a critical moment that created the opportunity for MSF and the IOM as 'advocates of proposals to push their pet solutions, or to push attention to their special problem' (Kingdon, 2011: 165). This policy window fits within a long tradition of humanitarian intervention and emergency politics (Chigudu, 2017: 124, 125). For many, including humanitarian actors themselves, humanitarian aid is 'immediate, urgent, and temporary care [solutions] in the name of political neutrality' (Chigudu, 2017: 137), that actions the belief that 'a combination of money, technology and goodwill can solve any problem' (De Waal, 2013: 63). However, as multiple case studies and a growing body of literature show, this is a misrepresentation of the broader political and social context through which the 'crisis' and/or 'emergency' is created, as well as the political and social calculations and costs taken into consideration when a situation is deemed a 'crisis' (De Waal, 1997, 2010; Fassin, 2010, 2012; McFalls, 2010; Redfield, 2013).

Framing or understanding something to be a 'crisis' lends itself to a particular response. To use Stone's conceptualisation of 'issue framing', the process through which advocates:

> select some aspects of perceived reality and make them more salient [important or visible] … in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendations (Robert Entman, 1993 in Stone, 2012: 252, 253)

By declaring Vhembe, and specifically Musina, to be in 'crisis', the 'issue' – a significant number of Zimbabweans in Musina in need to medical care, documentation, and

accommodation – legitimated the involvement of organisations like MSF and the IOM. In fact, it became the logical response (Fassin and Pandolfi, 2010).

After the initial 'crisis' dissipated, organisations like MSF and the IOM were able to take advantage of the fact that their presence in Musina had already been legitimately established to develop and implement longer-term projects that were more developmental in nature, like those with migrant farm workers. Illustrating the blurred boundaries between humanitarian aid and development – 'attempts to produce long-term social, economic or political change' (Crewe and Axelby, 2013: 4; de Gruchy and Kapilashrami, 2019).

The longer-term engagement of these actors within Musina meant that migration and health in general, and the health and well-being of migrant farm workers specifically, remained on, and in many ways dominated, the local agenda for a specific period of time. For example, migrant farm workers, specifically their health and well-being, features as a key item on agendas of the VDMHF from 2011 until early 2016. However, given the nature of iNGO interventions de Gruchy and Kapilashrami, 2019), the involvement of both organisations in Musina inevitably came to an end. MSF left the area in 2013 due to their own desire to only be involved with the project for a period of five years, as they try 'to innovate and to try models of care that [they] think are going to help the system' and that can be replicated by the state (iNGO_01) (de Gruchy and Kapilashrami, 2019). While at the time of writing (August 2019), the IOM still have an office in Musina, the organisation is no longer involved in migration and health related activities in the area.

For the DoH, and other state entities beyond Musina, migration and health does not appear to have made the same kind of impact on their agenda. While the District and Province appear to have been interested in and supportive of these interventions when they were initially developed, with a few notable exceptions, civil servants at the District

and Provincial levels appear to have not been particularly engaged with the interventions and their development, or with migration and health more broadly. As one IOM representative noted:

> I was quite surprised the other day when we were meeting the [civil servant in the DoH Limpopo], after we met him several times, he asked me 'is IOM doing work in the Province?' and I wanted to name several meetings where we were there and made a presentation, meetings that he chaired, but we can't do that. (iNGO_02)

This shift in focus by the state, specifically the DoH, from migration and health can broadly be understood as a result of two factors. Primarily, without a 'crisis' to attract and direct material resources and political will to issues of migration and health the issue has less salience for state actors. Secondly, other issues and concerns now dominate the agenda. A key example of this is that, in 2012, Vhembe became a pilot district for the National Health Insurance (NHI). Consequently, much of the attention of the District has been on piloting key mechanisms of the NHI, including sub-programmes focused on improving existing infrastructure and an Integrated School Health Policy (Genesis et al., 2019). In addition, rather than focusing on sustaining existing cadre of community-based healthcare workers (de Gruchy, 2019), importance has instead been placed on developing Ward-Based Outreach Teams (WBOTS), the latest iteration of community-based health care workers seen in South Africa, this time attached to the NHI. This shift in attention, as well as the fact that the interventions by MSF and the IOM were not sufficiently integrated into the DoH, has had serious implications for the sustainability of these programmes (de Gruchy and Kapilashrami, 2019).

Exploring and analysing the empirical data collected on the development, intervention, and, in particular, sustainability of the IOM and MSF programmes with migrant farm workers in Musina created a picture that existing theories and frameworks of policy

process can only partially explain. Some concepts, for example the policy window from the Multiple Streams Approach, as detailed above, are helpful in understanding the creation of the initial responses in Musina. However, four parts of the process broadly exist in tension to theories of policy process.

The first tension that emerges concerns the temporal aspect of the processes. In this case study, the intervention of the iNGOs and establishment of their programmes was particularly rapid, but not long lasting. Within most theories of policy change there is generally an understanding that the right 'moment' is needed to elicit change. However, longer-term time frames, and the effect of time on the sustainability of policy changes and programmatic interventions is by and large not acknowledged by this body of work. For example, the ACF acknowledges that a long-term perspective is needed to understand policy change and that coalitions – networks of 'actors sharing policy core beliefs who coordinate their actions in a nontrivial manner to influence a policy subsystems' - can have longevity (Jenkins-Smith et al., 2014: 195). But the bulk of the conceptualisation of time happens around understanding why a particular moment allows for policy change through, for example: an external shock or perturbation – 'events outside the control of subsystem participants', including 'extreme events such as some crises and disasters' (2014: 202); internal shocks or events – events that 'occur inside the territorial boundaries and/or the topical area of the policy subsystem'(2014: 202); or learning and negotiated agreement (2014: 202, 203).

Similarly frameworks like Walt and Gilson's and the 3 I's acknowledge the importance of a particular moment within the 'context' and as central to the 'process' (Walt and Gilson, 1994) and in allowing particular ideas and interests to come to the fore (Gauvin, 2014). However, in addition to the fact that the temporal aspect is implicit rather than explicit in these frameworks, the longevity and sustainability of the policy change that a particular moment allows for are not taken into consideration.

Consequently, the second tension that emerges between this case study and these theories is around sustainability. In general, theories of policy change stretch to implementation and an acknowledgement that implementation, - the ways in which policy is interpreted, negotiated, and executed - is a key stage of the policy process (Agyepong and Adjei, 2007; Béland and Ridde, 2016; Betts and Orchard, 2014; Howlett, 2018). However, I would argue that we need to understand the policy process as including a further step – if and how programmes and policies are maintained and sustained.

Sustainability is a key theme in the literature on non-governmental interventions, including humanitarian agencies and funders, in local contexts (Berlan and Bruno-van Vijfeijken, 2013; Cairney and Kapilashrami, 2014; de Gruchy and Kapilashrami, 2019; Schell et al., 2013; Shigayeva and Coker, 2015; Younis, 2007). Given the central role that such actors play in the provision of services, including healthcare, in LMICs, an improved understanding of these actors in the policy process and the consequent implications for sustainability should therefore inform our thinking and conceptualisation of policy processes. In addition, sustainability, and if or how the state ensures the sustainability of programmes is, I would argue, key to understanding the importance of the policy or programme in question for the state. To agree to the implementation of a programme with no intention of sustaining it is different to agreeing to the implementation of a programme with the intention of sustaining it. The fact that the state has displayed little interest in sustaining the Musina Model of Care, for example, throws into sharp relief the fleeting nature of the migration and health agenda for the state. While the health of migrant farm workers may have appeared to dominate meeting agendas and local working relationships while MSF and the IOM were heavily involved in the area, this does not appear to have shifted the deeper, institutionalised agenda of any of the state departments and entities

involved. This highlights the impenetrability of the state and its decision-making apparatus, to which I will return later in this section.

The involvement of non-governmental organisations, including United Nations agencies, humanitarian organisations, and funders, in this context creates a third tension between the empirical data from this research and existent theories. These organisations are not explicitly excluded from theories of policy process. Much literature acknowledges the role that civil society plays in the policy process, particularly agenda setting, globally (Kapilashrami and O'Brien, 2012; Khan et al., 2018; de Gruchy and Kapilashrami, 2019; Smith, 2019), and that international organisations, humanitarian, and United Nations agencies play in governance within LMICs (Adhikari et al., 2019; Biesma et al., 2009; Cairney and Kapilashrami, 2014; Kapilashrami and McPake, 2013; Kavanagh and Dubula-Majola, 2019; Nunnenkamp et al., 2016; Pfeiffer, 2003; Wilhelm-Solomon and Pedersen, 2017). However, through a reading of theories and frameworks of policy process, they are primarily treated as yet another actor in the process. What this case study shows is that MSF and the IOM both responded to the 'crisis', and were themselves an 'external perturbation' that needed to be responded to by the state. Their involvement elicited a series of responses from the South African state, for example in agreeing to take over the Musina Model of Care. Similarly, just as the 'crisis' dissipated, these organisations left and the state could redirect its attention and energies elsewhere.

Here, Kingdon's concept of 'policy entrepreneurs' is particularly useful (Kingdon, 2011: 179–181). Policy entrepreneurs are those who are 'willing to invest their resources – time, energy, reputation, money – to promote a position in return for anticipated future gains in the form of material, purposive, or solitary benefits' (Kingdon, 2011: 179); 'when researching case studies,' Kingdon notes 'one can nearly always pinpoint a particular person, or at most a few persons, who were central in moving a subject up on the agenda and into position for enactment' (2011: 180). While this concept was

built from an understanding of the role played by lobbyists in the United States, I believe that it is useful in informing an understanding of the role played by MSF and the IOM. Both organisations were able to leverage their expertise and the moral economy of humanitarianism during the policy window created by the 'crisis'. In addition, Kingdon argues that 'entrepreneurs do more than push, push, and push for their proposals or for their conception of problems. They also lie in wait – for a window to open' (2011: 181). This is an important consideration as it adds weight to the idea that the response of organisations like MSF and the IOM to the 'crisis' in Musina was not simply a neutral humanitarian response. Instead, it was an opportunity for both organisations to legitimately intervene in Musina around migration and health, a geographic and thematic area in which both organisations indicate that they were interested in prior to their involvement.

Finally, these approaches all fail to capture the impenetrability of the South African state. Although the South African state has a decentralised structure, the implementation of this has by and large been poor (Landau and Singh, 2008; McIntyre and Klugman, 2003; Siddle and Koelble, 2013). Within the DoH, for example, decision making has remained centralised and poor governance structures have undermined workplace trust, policy implementation, and service delivery (Gilson et al., 2005; McIntyre and Klugman, 2003). Furthermore, mandates are clearly demarcated across departments. Migration is a key example of this. The Department of Home Affairs (DHA), and in some select instances the Department of Labour (DoL), are the only two state entities with a mandate to respond to migration. As such, even though local government has a developmental mandate and research points to the centrality of local government in improving responses to migration, there has been a distinct lack of response from this sphere of governance to migration (Landau and Singh, 2008; Vearey, 2011).

Many of the theories and frameworks for understanding policy process however seem to take as a central point of departure the idea that the state is responsive; when there is an external perturbation and policy entrepreneurs or an advocacy coalition are able to take advantage of it, there is a shift in the interests and ideas at play within the state and resources can become available to elicit a change. Implicit in this understanding is the idea that the state is responsive when specific factors come together. In this case, the state did respond to the crisis and the involvement of international organisations in the area by, for example, attending VDMHF meetings and taking over the Musina Model of Care. However, beyond this, little response was forthcoming from the state. In addition, the response that was seen from the state could be read as a response to the presence of the organisations (as an external perturbation themselves), rather than to the crisis itself.

Bearing these four tensions in mind, as well as the particularities of this case study, I have developed a conceptual framework that I believe captures the variety of actors and temporal nature of policy making seen here.

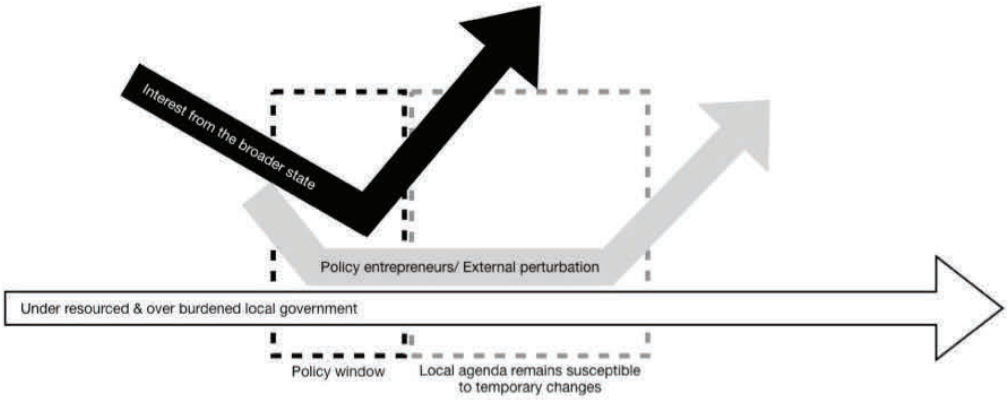

Figure 1: Conceptualising the policy process

As shown by Figure 1, the policy window created by the deterioration of conditions in Musina and subsequent declaration of a 'crisis', elicited a response from international

organisations as policy entrepreneurs. The 'crisis' and the response by international organisations in turn elicited a response, in the form of material and political support, from the state at District and Provincial levels. This support lasted into the period during which development interventions were implemented and migration and health was a focus of the local agenda. As such, both the District and Province agreed to participate in the VDMHF and to take on the Musina Model of Care when MSF left. However, as the figure shows, the interest of the broader state in migration and health in Musina was short lived.

If we take a slightly longer-term look, the broader state was interested once more in Musina a few years later when Vhembe was selected as one of the priority districts in the 2012 – 2016 National Strategic Plan for HIV, STIs, and TB (NSP) and became one of the pilot districts for the NHI. In fact, if two of these figures are superimposed, the states renewed interest in the local context begins to create a pattern:

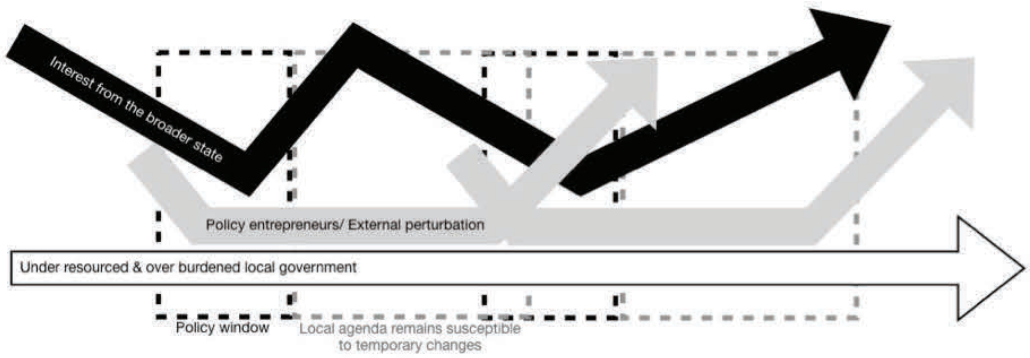

Figure 2: A longer-term view

This figure is able to capture the relationship between the local government in Musina, the interest of and support from the broader state in the area, and the involvement of policy entrepreneurs, such as international organisations. While the NHI and NSP directed the attention of the state once more towards Musina, it also created interest

from funders – as policy entrepreneurs – in the area. The President's Emergency Plan for AIDS Relief (PEPFAR) for example, funded the IOM's migration and health programming in Musina, as well as the DoH in Vhembe, between 2012 and 2016. This also suggests a series of feedback loops between state and non-state responses. Additionally, what begins to emerge is the beginning of a pattern in which material resources and political support come together as policy windows open, but, as they close, interventions are not sustained and strategic opportunities to engage with migration and health are lost. What this figure is able to capture is both the reactive nature of responses to migration and health – reliant on a moment of crisis that brings together actors, resources, and political will. And the temporal aspects of such responses – implemented during particular moments and not sustained.

This figure is able to bring together both existing conceptualisations of policy change, as well as provide mechanisms to understand the four key tensions that have emerged between the empirical data and the literature.

Conclusion

As I have argued in more detail elsewhere, this way of responding to migration and health undermines the access that migrant farm workers, as well as other migrant and mobile communities, have to determinants that would positively affect their health, including the healthcare system (de Gruchy, 2019; de Gruchy and Kapilashrami, 2019; de Gruchy and Vearey, 2019). This consequently undermines South Africa's commitment to 'leave no one behind' in the realisation of Universal Health Coverage (UHC) and meeting global health targets, including UNAIDS 90:90:90 (de Gruchy and Vearey, forthcoming).

The existing theories and frameworks with which I engaged throughout this research have provided useful concepts for understanding key moments and interactions between state and non-state actors. However, they have by and large failed to capture the temporal and reactive aspects identified in the case study.

Within a context, such as South Africa, where good governance is lacking and service delivery remains poor, with implications for South Africans and non-nationals (Alexander, 2010; Amit, 2012; Chipkin and Meny-Gilbert, 2011; de Jager and Musuva, 2016; Habib et al., 2003; Misago, 2016; Siddle and Koelble, 2013), understanding how and why programmatic interventions do not lead to longer-term change or programmatic sustainability is imperative. What this paper is able to show is that the current approach to areas of governance that require state, and non-state, co-ordination and sustainability, like migration and health, are reactive and timebound. Rather, what is needed are approaches to policy and programmatic development that are able to shift this way of responding. Recent calls for migration-aware and mobility-competent policies and programming (Vearey et al., Forthcoming, 2017; Wickramage and Annunziata, 2018) are an example of what a radical restructuring of approaches to policy making around migration and health could be.

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[i]This paper is exclusively concerned with cross-border migration. As such 'migration' and 'migrant(s)' refers to movement across international borders and those who engage in such movement respectively unless otherwise indicated.

[ii] This is an ambitious target and meeting it would mean that by 2020, '90% of all people living with HIV will know their HIV status'; '90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy'; and '90% of all people receiving antiretroviral therapy will have viral suppression' (UNAIDS, n.d.)

8 Discussion

As the four papers that precede this Discussion show, the process of developing, implementing, and sustaining policy and programmatic responses to migration and health in Musina was fraught and, in many ways, at odds with existing theories and understandings of policy processes. The four key findings that emerged through this research have been discussed in various ways across the four papers, a summary of which can be found in Table 9. The shaded cells indicate in which papers the theme in question is a focus.

Table 9: Themes and papers

Key finding	**Paper 1** De Gruchy & Vearey, in press	**Paper 2** De Gruchy & Kapilashrami, 2019	**Paper 3** De Gruchy, 2019	**Paper 4** De Gruchy, submitted
Social Determinants of Health (SDHs) for migrant farm workers are vast and access to positive determinants is poor (too complex for a decentralised and siloed approach)	Outline the SDHs for migrant farm workers and their limited access to positive determinants			Developing responses to this context is undermined by the realities of governance in South Africa
State responses to the health and wellbeing of migrants are usually crisis-bound and targeted	No long-term engagement with migrant farm workers by the state	Musina Model of Care as a case study of this	CHWs and Change Agents as an example of this	A crisis, as well as the involvement of iNGOs in a context, brings together the material resources and political will to develop a short-term response from the state
Non-state interventions are timebound, localised, and not politically supported		Musina Model of Care as a case study of this	CHWs and Change Agents as an example of this	A crisis creates an opportunity for iNGOs to legitimate their involvement in a local context
Community-based Health			CHWs and Change Agents as	

Care Workers can form part of a migration aware response to health			an example of this	

At the outset of this research, my research question read:

> Given the lack of locally-relevant policy frameworks, and the limited nature of both research on and responses to migration and health, can a case study of policy and programmatic responses to the health and wellbeing of migrant farm workers in Vhembe District, Limpopo inform a conceptual framework that is able to improve understandings of policy processes around migration and health in South Africa?

In addition, five objectives were laid out:

1. To develop an improved understanding of migration and health within the South African context, specifically of the health and wellbeing of migrant farm workers;
2. To understand how policies on issues of migration and health are framed in South Africa;
3. To investigate the development of policy and programmatic responses to migration and health in South Africa, from agenda setting to implementation, and experiences thereof;
4. To be able to explain, conceptually, why policies are made or left un-made, and in so doing address the limitations of existing frameworks; and
5. Reflect on lessons learnt for future advocacy for better policy processes around issues of migration and health in South Africa.

While these questions have implicitly been responded to throughout the papers and this chapter, I turn now to present these responses more explicitly. Drawing on the key findings and arguments built in the papers, in this chapter I will briefly articulate a response to my first three research objectives. I will then present a broader discussion of additional data that emerged during the research, findings that speak to the implementation of policy in the agricultural sector in South Africa, the role of non-state actors in this process, and the opportunities and limitations provided by the state's decentralisation. The research question and fourth conceptual objective will then be discussed in the Conclusion. A response to the fifth and final objective, lessons for future advocacy, follows. Finally, at the end of the Conclusion chapter, there will be a brief discussion of the way forward and opportunities for future research.

8.1 An improved understanding of migration & health in South Africa

The first objective of this research was to improve the understanding of migration and health within the South African context, specifically with regards to the health and wellbeing of migrant farm workers. This research has brought to the fore the lived experiences of migrant farm workers, as a migrant and mobile community, through an analysis of the Social Determinants of Health (SDH) found de Gruchy & Vearey (in press) [Paper one], as well as by highlighting the ways in which the interventions by Médecins Sans Frontières (MSF) and the International Organization for Migration (IOM) were able to improve the access that this community had to healthcare (de Gruchy, 2019; de Gruchy & Kapilashrami, 2019) [Papers three and two respectively]. This research has highlighted the moments at which migration and health is responded to – moments of crisis and intervention – at the expense of migration-aware and mobility-competent policies and programmes. Additionally, this research has contributed to an improved understanding of the intersection between migration and health and the governance of labour. As such, using a case study of the access that migrant farm workers have to health in Musina, this research has contributed to the growing call for a proactive response to migration and health in South Africa, and globally (Vearey et al., 2019; Vearey, Modisenyane, et al., 2017; Wickramage & Annunziata, 2018).

8.2 Issue framing

Understanding how policies on issues of migration and health are framed in South Africa has been the second objective of this project. Generally the first step in the development of a response is getting the issue to which a response is necessary on the agenda of the relevant governing authority (Kingdon, 2011; Stone, 2012). Kingdon refers to this as the creation of a 'policy window' - an opening that provides an opportunity for 'advocates of proposals to push their pet solutions, or to push attention to their special problem' (Kingdon, 2011, p. 165). A process that Stone, and others, refers to as 'issue framing':

> to select some aspects of perceived reality and make them more salient [important or visible] … in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and /or treatment recommendation. (Robert Entman, 1993 in Stone, 2012, pp. 252, 253)

As this research makes clear, the joint issues of migration and health are by and large not framed as a concern warranting engagement at a national level in South Africa.

The ways in which migrants and their access to healthcare are engaged with fits within the increasingly popular securitisation of migration paradigm, and promotes the regression of rights to which migrants are entitled; their access being framed as infringing on the rights of South African nationals, a key example of this being the *National Health Insurance (NHI) Bill*, as discussed in sections 1.2, 2.2, and 2.3. In Musina, however, alternative understandings of the issue and responses to it were forthcoming during the 'crisis' of 2008/2009. The policy window created by the crisis also created opportunities for alternative responses to other vulnerable populations, in this case migrant farm workers, to be developed by MSF and the IOM. However, as these responses were largely developed by non-state actors, while their involvement in the area certainly affected the framing of the issue by those directly involved in the Musina Model of Care, Vhembe District Migrant Health Forum (VDMHF), and Change Agent programme, it was unable to permeate broader levels of governance, as has been discussed in detail in de Gruchy (submitted) [Paper four].

8.3 Policy process(es)

The third objective of this project has been to investigate the development of policy and programmatic responses to migration and health in South Africa, from agenda setting to implementation, and experiences thereof. This has been discussed in some depth in de Gruchy (submitted) [Paper four], but a brief overview will be provided here. What this research has identified was that there were essentially two parallel policy processes in Musina. On the one hand, iNGOs - in this case MSF and the IOM - already concerned with the access that migrants have to health responded to a moment of crisis. Given the moment of crisis, their involvement in the area was perceived as legitimate. Both organisations then went on to use this as an opportunity to implement longer-term developmental programmes (de Gruchy & Kapilashrami, 2019) [Paper two]. However, due to the nature of iNGO work, neither organisation is currently involved with migration and health programming in the area. MSF have left the area and the IOM are currently not undertaking any work related to migration and health in Musina. As such, neither organisation is currently involved in sustaining the programmes (de Gruchy & Kapilashrami, 2019) [Paper two].

On the other hand, the state, during a time of crisis, welcomed the expertise and resources offered by the organisations, and in response to both the crisis and the involvement of these organisations, concerns with migration and health were placed high on the state agenda. For example, civil servants from the sub-district, district, and province attended VDHMF meetings; the local mobile clinic worked with and

ultimately took over the Musina Model of Care and its migration-aware components; and the Change Agents were acknowledged as a legitimate cadre of community workers with whom the mobile clinic healthcare providers could work (de Gruchy, 2019) [Paper three]. However, once the organisations left the area, migration and health slipped from the agenda and, while no decisions were taken to roll back the access that migrant farm workers have to HIV care, the programmes have not been actively supported and sustained. In a sense, the involvement of MSF and the IOM in Musina and the subsequent attention given to migration and health is a short diversion in the longer history of the DoH in Musina, and in Vhembe, and their concerns (de Gruchy, submitted) [Paper four]. Furthermore, as focus has shifted at both the National and Provincial levels, specifically to the implementation of the NHI, the focus of the District and sub-district have shifted. This highlights how policy making remains centralised within the DoH, and within South Africa more generally.

This raises questions about our understandings of policy making that traditionally end at implementation. Should efforts to sustain the implementation of a policy also be seen as part of a policy process? If the state knows that the organisations concerned with migration and health will leave and that they, as the state, will not sustain the programmes, can the state be said to have been supportive of the programmes in the first place?

These questions treat the state as monolithic, when we know that the state is comprised of multiple, competing actors at any time. For example, the manager of the mobile clinic and the representative from the Office of The Premier (OTP) have always championed (to use the description provided by a key informant from MSF, iNGO_01) the interventions and their importance. However, in other ways the state acts in a very monolithic way. Migration and health is not a priority of the DoH nationally or indeed provincially. With a nationalistic agenda dictating the use of resources and priorities, even when multiple state actors champion an alternative cause it is by and large futile.

On this note, I turn to a discussion about additional findings from this research that I was not able to include in the papers but, nonetheless, work to inform an improved understanding of the context surrounding the responses to migration and health in Musina. Specifically, their implementation and efforts, or the lack thereof, to sustain them. This discussion provides additional support to the conceptual framework that I present in de Gruchy (submitted) [paper four] and in response to my fourth research objective.

8.4 Additional discussion

8.4.1 Further complicating access to positive determinants of health for migrant farm workers

The first key finding that emerged from this research, and that is discussed in detail in (de Gruchy & Vearey, in press) [Paper one], is that the particular context within which migrant farm workers in the area around Musina find themselves limits their access to positive determinants of health. As Vearey and I argue, this will undermine South Africa's efforts at Universal Test and Treat (UTT), Treatment as Prevention (TasP), and other strategies that aim to improve access to HIV care and treatment across the country (de Gruchy & Vearey, in press) [Paper one]. Ultimately, leaving such populations behind will hamper South Africa's efforts to meet its global commitments, for example to implement Universal Health Coverage (UHC) and meet UNAIDS 90:90:90 targets. One of the issues that is touched on in this paper is the fragmented nature in which the agricultural sector, specifically as it pertains to farm workers, is governed in South Africa, and how this complicates responses to the health and wellbeing of migrant farm workers. I go on to consider this in more detail below, specifically in relation to how it complicates the implementation of responses to migrant farm workers.

As briefly noted in section 2.2.1, state regulation of the agricultural sector involves multiple departments all with varied mandates and responsibilities. For example, the Department of Agriculture, Forestry, and Fisheries (DAFF) is responsible for 'scientific and technical support to farmers' (DAFF_01), but does not have a mandate with regards to farm workers. Instead, the Department of Labour (DoL) is tasked with ensuring that the conditions of the *Basic Conditions of Employment Act* (1997) (BCEA) are met, as well as those of the *Occupational Health and Safety Act* (1993) (OHSA). While farm workers are expected to access healthcare through the DoH. For remote communities this often renders healthcare inaccessible.

Within this context, the existence of a mobile clinic like the one in Musina therefore does much to improve the affordability and accessibility of care. However, like the access of the DoL to the farms, interview data and observation of the mobile clinic programme indicates that whether workers have time to visit the clinic or if the clinic is allowed access to the compound and farm property is subject to the farmer's support of the programme. Some farmers have built structures with the clinic's visits in mind, while others do not allow the nurses on to their property, forcing, in one observed incident, workers to climb under or over fencing to access the clinic.

The response from farmers and farm management towards the state and the state's involvement on the farms is characterised by two competing narratives. On the one hand, the farm is seen as 'private property', 'similar to a factory, similar to my house' (Agri_03), a space in which the state should not intervene. Several research participants, primarily those affiliated with the conservative Transvaal Agricultural Union (TAU)[30] lamented the loss of the 'very close and healthy relationship' (Agri_03) that farmers felt that they shared with workers during Apartheid, prior to perceived state interference through social policies. As one representative of a farmers' organisation argues in relation to what is perceived to be an invasive regulation of labour in the sector:

> A farmer wants to farm, even though there's a lot of pieces of legislation governing his operations, he wants to farm, he doesn't want to be involved in labour conflicts or things like that … they (farmers) hate labour inspectors. (Agri_01)

As discussed in section 2.2.1, efforts post-1994 to improve the protection offered by the state to farm workers has been seen by farmers as threatening and has led to the loss of 'racialised paternalism' (Bolt, 2017; Devereux, 2019). Simultaneously however, farmers lament the failure of public policy and the lack of state support and involvement in providing services to farm workers.

With regards to the education of the children of farm workers for example, one participant highlights the frustration felt by farmers in this regard:

> That's why a lot of thinking amongst the farmers are we must stand together, put up clinics, put up nursery schools…How's government going to react to it? What stupidity will come with that to your area? Because you can put up the school, but they would want to be the boss. (Agri_02)

[30]The TAU, or Transvaal Landbou-unie (in Afrikaans), is a conservative organisation for commercial farmers. Originally an affiliate of the South African Agricultural Union, in the 1990s, as the Agricultural union refashioned itself as AgriSA and committed to working with the post-apartheid government, the TAU broke with the organisation over 'political differences' (Agri_03). While the TAU became a national organisation willing to cater to more conservative farmers, the majority of its members remain in provinces that were part of the Transvaal during Apartheid - Mpumalanga, Limpopo, the North West, and Gauteng.

In Musina, some 80 per cent of workers live on farm compounds (International Organization for Migration, 2010, p. 8), accommodation provided by the farmer to the workers on farm property. As the Sustainability Initiative of South Africa (SIZA) note, while:

> there is no legal obligation on any employer to provide accommodation, where accommodation is provided as part of an employment contract, management should accept responsibility for ensuring that the accommodation is adequate, safe and hygienic and meets any requirements of law. (2013, p. 3)

The lack of state support in building and maintaining this accommodation is a further source of frustration for farmers. Particularly given that during Apartheid farmers received subsidies. Since 1994, however, the agricultural sector has been deregulated and been at the centre of calls for land reform (Kalaba, 2015; Visser & Ferrer, 2015), something that farmers perceive as a direct threat and attack by the state on them and their livelihood. As one farmer notes:

> As I say, the whole government is very agricultural unfriendly, and that we feel really the last 20 years. I mean, the whole time in the media we are made the criminals of South Africa; we stole the land…Yes, they (the government) worry on paper about the vulnerable farm workers. But do they really care? I would say no, they don't care. They worry if I (as a farmer) treat them right, yes. (Agri _04)

In Musina, part of the frustration expressed by both farmers and workers with the state centres around the employment of non-nationals. Farmers maintain that South African workers are hard to come by in this area, and are not interested in farm work. However, in order to employ non-nationals, farmers are required to go to the DoL in Musina and provide them with the job descriptions, salary and contract details of employment opportunities. The DoL then provide the farmer with a list of potential employees who have registered with the DoL and have the requisite skills (DoL_01; Mgt_01). One farmer indicated that of the 550 workers he had needed for a particular season, he had been able to hire 67 workers through this process (Mgt_01), something that farmers argue is indicative of the lack of interest and experience in farm work among South Africans in the area. The DoL then issues a certificate to the farmer indicating that the farmer has hired as many South Africans as possible. This allows the farmer to approach the Department of Home Affairs (DHA) to apply for a corporate permit in order to hire non-nationals. Corporate permits are held by

employers, in this case farmers, and allow the employer to hire a set number of non-nationals for a specific number of years, on the understanding that there are no suitable South African candidates. Non-nationals are chosen by the employer to be included on the permit. If a worker chooses to leave the farm during the permit period, they lose their documentation and the farmer is unable to replace them. Everyone involved in this process, including the workers, is very aware of the fact that without this permit a worker would be undocumented, as they are not eligible for any other kind of documentation. As much as farmers are reliant on non-nationals for labour and on corporate permits to access this labour, the reliance of the workers on the farmer to provide documentation, work, and income through the permit is clearly understood by all parties. Farmers lament this process primarily because historically they were allowed special leeway in hiring non-nationals; border officials would view a note from a farmer as official documentation should they stop a non-national farm worker (Bolt, 2016a). In addition, the process is particularly time consuming. Farmers indicated that they submit their corporate permit application seven or eight months prior to when they anticipate needing labour.

While most of the farmers that I interviewed indicated that they were trying their best to conform to state regulations, most expressed frustration at both the increasing financial burden that state regulations have for them, and the limited state support that they receive. However, while state regulations and standards are important to farmers, general consensus is that inspections done by global standard bearers are far more critical. The importance of Global G.A.P., as a global standard bearer of fresh produce, and the importance of global standards and markets emerged as a key structural determinant of farm worker health in de Gruchy and Vearey (in press) [Paper one]. Global produce standards proliferated in the early 2000s, but among these, Global G.A.P. has emerged as a 'cause célèbre' (Henson et al., 2011, p. 375), G.A.P. standing for Good Agricultural Practices. Globally, they are 'the most widely implemented farm certification scheme' (Eurofruit Magazine, 2008 in (Bain, 2010, p. 2)). While there is some debate in the literature about the balance of power between retailers and suppliers within Global G.A.P. (Bain, 2010), what is clear is that workers are not a priority in these standards. Bain (2010) in fact details how Chilean suppliers were able to exercise their power within Global G.A.P. to scale back the requirements with regards to labour in the certification process. As Global G.A.P. increases its dominance in the field, and partners with other standard bearers and states to harmonise certification processes (a process currently underway in South Africa, Pvt_02) the worker and their health and wellbeing is likely to become even less of a priority.

What emerges as particularly relevant for an analysis of why improved policy and programmatic responses to the health of farm workers have not been forthcoming are the difficulties of trying to develop responses given the fragmented and siloed mandate of the state with regards to this complicated landscape. A landscape characterised by historical modes of domestic government and threats to them, and the increasing importance of international standard bearers and global markets. Within this context, access to positive determinants of health for migrant farm workers is limited.

8.4.2 The role of non-state actors in responding to migration and health: A brief reflection on the Vhembe District Migrant Health Forum

Within this context, the efforts that have been made to improve the access that migrant farm workers have to healthcare in general, and HIV care and treatment specifically, have been instigated by non-state actors – MSF and the IOM in this case – during moments of crisis. However, as argued in de Gruchy and Kapilashrami (2019) [Paper two], this has undermined the sustainability of the interventions and meant that responses to the health of this population have remained tied to these moments of crisis rather than resulted in the development of migration-aware health policies and programmes. This begs the question: what role do non-state actors play in health governance in South Africa? Aside from acting as service providers, do these organisations shift the health agenda and does their involvement precipitate policy change? This section provides a reflection on these questions, followed by a reflection on the Vhembe District Migrant Health Forum (VDMHF). While this intervention has been touched on briefly across the papers, it has not been used as a case study in its own right. As such, the VDMHF will be discussed in more detail in this section as a third example, in addition to the Musina Model of Care and Change Agents programmes, of an iNGO initiated programme that was handed over to the state and which has since struggled with issues of sustainability.

When asked about the reasoning behind MSF's project in Musina, the MSF Medical Coordinator to South Africa remarked:

> Look, like any resource allocation process, there's a rational element to it, and there's a more subjective element to it; like with any human decision-making process. So, um, what we try to look at objectively is who else is there, what are the needs, and what's our capacity to respond to those needs. And in the South

> African context a lot of that is to do with what (who) are the partners on the ground that we can work with and what's our likelihood of being able to work with those partners. Then we also look at consistency with our organisational mandate. So obviously, we're a medical humanitarian organisation. And we look for you know when we say needs, we're looking at both medical and humanitarian needs. And in a context like South Africa, where MSF could leave tomorrow and the health system would be fine, we have to think what's our added value. And our added value we see as being to demonstrate different ways of doing things which are in some way replicable by the national system. (INGO_01)

Since the 1990s, the MSF Association in South Africa, attached to the Brussels Operational Centre, has been able to demonstrate particularly innovative ways of improving healthcare in various contexts across the country. The organisation is primarily supported through private donations from individuals, due to the political costs of accepting funding from governments (iNGO_01). In addition to several projects that the organisation is currently running in South Africa, MSF is also involved in advocacy campaigns, including Stop Stockouts and Fix the Patent Laws (Médecins Sans Frontières, 2018). Most recently, the organisation has opened the Tshwane Migrant Project, a clinic that 'will provide a supportive, specialised HUB (sic) for vulnerable people, focusing on undocumented migrants, asylum seekers and refugees living in the greater Tshwane (Pretoria) area, who are often unable to access appropriate health care and/or social services' (Médecins Sans Frontières, 2019b). Many of these projects have been and are heralded a success, including most recently the Bending the Curves project in Eshowe, which has met and exceeded the UNAIDS 90:90:90 targets (Médecins Sans Frontières, 2019a).

However, there is limited evidence that these projects are sustained by the DoH, or other stakeholders, once MSF leaves. In the example of Musina, ten years after the arrival of MSF, the IOM, and various other organisations to respond to the 'crisis', things have by and large returned to normal. At the height of the involvement of these two organisations in the area a well-stocked and supported mobile clinic provided HIV care to migrant farm workers across the area, supported by a cadre of trained Community Health Workers (CHWs); over a hundred Change Agents provided support to migrant farm workers and assisted the IOM and the Centre for Positive Care (CPC) in organising soccer tournaments and other social opportunities at which Voluntary Counselling and Testing (VCT) was conducted; and the VDMHF existed as

a dynamic space to which organisations and individuals, including representatives from the Office of the Premier (OTP), could attend and:

> hang lose [trouble shoot] where challenges are and where possible, and within their mandates, the relevant stakeholders are actually trying their best to address [these] many challenges that are experienced by migrants from the health point of view (OTP_01)

When I first visited Musina in 2015, as part of a different, but related, research project, although MSF had already left the area, many of the other iNGOs remained; the VDMHF was a very well attended space run by the IOM as Secretariat; the potential for the Musina Model of Care to be scaled up and used as a model in other sub-districts was discussed by the manager of the programme; and the Change Agents appeared to be vibrant groups, supported by the IOM and CPC, at various points morphing into drama collectives and at others participating and organising dialogues and sporting events.

Over the three years (2016 – 2018) that I visited Musina as part of this PhD project, things changed quite drastically. While the Musina Model of Care still provides VCT and antiretroviral therapy (ART) to migrant farm workers, the previous excitement around the programme has dissipated; the CHWs are no longer in a position to provide the kind of support that they used to; the Change Agents report feeling largely despondent and frustrated by the expectation that they will continue to volunteer within the communities without remuneration and support (de Gruchy, 2019) [Paper three]; and a new manager has taken over the mobile clinic programme (de Gruchy & Kapilashrami, 2019) [Paper two]. This new manager arrived in early 2018, and as I had completed my fieldwork has not featured strongly in my data or analysis. However, throughout the research many key informants reflected on her predecessor, the manager of the mobile programme during the implementation of the Musina Model of Care, as a key reason for its success:

> And I think it's worth saying that to me it really shows the importance of these kinds of champions. So, this lady, [mobile clinic manager] … she's got so much energy, so much passion, she's the kind of person who can make something, make something happen you know. And those key people are very important to the project … but you've got to question a bit the sustainability of something if it becomes too reliant on that person… (iNGO_01)

Anecdotal insights indicate that her absence was already keenly felt in mid-2018 by healthcare providers working on the mobile clinic programme (de Gruchy & Kapilashrami, 2019) [Paper two].

Finally, in 2017, the President's Emergency Fund for AIDS Relief (PEPFAR) brought an end to its funding in Vhembe District. PEPFAR's funding for the District had been linked to the District's demarcation as a National Strategic Plan on HIV, STIs, & TB (NSP) Priority District between 2012 and 2016 (iNGO_02). IOM's health-related activities in Musina had been funded by PEPFAR and, as such, came to an end in 2017. Unlike MSF, the IOM's work has primarily been funded through Official Development Assistance (ODA). In South Africa, their migration and health programming has received support from PEPFAR, the Swedish International Development Cooperation Agency (SIDA), the Norwegian Ministry of Foreign Affairs, and the Southern African Development Community (SADC) HIV Special Fund (International Organization for Migration, 2019). This reliance on ODA, specifically from the United States (US), through PEPFAR as well as USAID, has emerged as a key factor in shaping the IOM's agenda (Pécoud, 2018), which, in South Africa, has been driven by a preoccupation with trafficking in persons (Palmary & de Gruchy, 2019). As PEPFAR funding was no longer available for the area, by 2018 (and at the time of writing, November 2019), the IOM Musina office had been downscaled and consisted of one employee working on Assisted Voluntary Returns. As such, the VDMHF has become the exclusive responsibility of the Vhembe District Municipality (VDM). Until 2017, the IOM had run the forum as 'the Secretariat' - maintaining the mailing list, organising meetings, and keeping minutes - responsibilities that were now handed over to the District. As with most things in Musina, the practical responsibilities were in fact given to the sub-district, and the then manager of the mobile clinic took over the role of organising the forum. Since then, communication and meetings have been infrequent. Reflecting on this, a representative of the OTP, who attended the VDMHF since its inception until his retirement in 2017, highlighted the reluctance of the District to commit to the forum:

> We have got serious problems with them (VDM); because in terms of the arrangement, when that forum was formed, the agreement or the arrangement was … that it's the property of the Vhembe District Municipality; so, they have to own it in every sense of the word. They have to see to it that the forum go(es) on and survive(s), but we have got the problem of that office in Vhembe District. The OTP has done a lot to get the Vhembe District to come to the party, but now and again we keep on revisiting the problem because it will get well

> for some few months and then it will go back to the same position now and again, so we're sitting with that problem.' (OTP_01)

In addition, while the local DoH uses the forum as a space in which to engage with other stakeholders, other government departments like the DoL and DHA, important stakeholders in conversations around migration and health, have been reticent to get involved:

> We're struggling to get DoL on board, we're struggling to get DHA on board, but OTP in many instances has been requested to, you know, get these core departments to attend. Not only the VMHF. But also, we're struggling to get them to attend other meetings such as the provincial steering committee for Save the Children South Africa. (OTP_01)

The role that non-state actors played in Musina can therefore be understood as one of 'innovation'; they did indeed 'demonstrate different ways of doing things which are in some way replicable by the national system' (iNGO_01). However, they have not been sustained by the state, let alone replicated. The case of the VDMHF supports the third key finding that emerged from this research – the reticence of the state in sustaining or developing migration-aware policies and programmes, a finding in line with much of the literature about iNGO involvement in local contexts (Berlan & Bruno-van Vijfeijken, 2013; Bruno-van Vijfeijken & Schmitz, 2011; Cairney & Kapilashrami, 2014; Kapilashrami & McPake, 2013; Younis, 2007) .

8.4.3 Decentralisation & local government's developmental mandate: Opportunities & challenges for the state responses to migration and health

The state's reluctance to sustain or implement migration-aware policies and programmes has been discussed across the dissertation, but highlighted in particular in paper three (de Gruchy, 2019) in relation to community-based healthcare workers.

The state's response to community-based healthcare workers – the literature around these workers having been discussed in some detail in section 2.2 – epitomises the various ways in which local government could, but fails, to realise its developmental mandate. In South Africa, as noted in section 2.1, local government is tasked with a 'developmental mandate': to work 'with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and improve

the quality of their lives' (Republic of South Africa, 1998). As many have argued, it is not possible to realise this mandate without engaging with population mobility, and indeed this provides an excellent opportunity to engage with migration and health specifically (Landau & Singh, 2008; Vearey, 2010, 2011a). Interestingly and importantly, the opportunities presented by the community-based healthcare worker programmes in Musina to realise this mandate were acknowledged by the DoH nurses working at a sub-district level in the mobile clinic programme. While not framed as an opportunity to realise the developmental mandate of local government, the nurses frequently reflected on the benefits that improving healthcare access for migrant farm workers had for the district, specifically with regards to improving morbidity and mortality rates. However, the potential of these opportunities does not appear to be acknowledged at the District level.

South Africa's DoH is underpinned by a District Health Systems (DHS):

> it is argued that being more than a form of organisation; the DHS depicts a set of activities such as community involvement, integrated and holistic health care delivery, intersectoral collaboration and a strong "bottom-up" approach to planning, policy development and management. (Fusheini & Eyles, 2016, p. 5)

However, in a geographically vast and demographically rural district such as Vhembe, it is the DoH at a sub-district level that is tasked with delivering on this mandate, while the DoH at a District level pulls the purse strings and responds to Provincial and National DoH policy. For example, Vhembe is a National Health Insurance (NHI) pilot district, which has brought with it an increased budget as well as a new set of health priorities (DoH_VDM), which have detracted attention away from maintaining already existing programmes and practices.

Within this context, the use of the term 'local', and our understandings of 'local government', require some attention. South Africa has a decentralised state structure. But while the idea of decentralisation in South Africa has merits, for example, in bringing government closer to the large rural black population in the country's hinterland, its application has been, in many regards, a failure (Chipkin & Meny-Gibert, 2012; Siddle & Koelble, 2013). Within this structure, there are understood to be three spheres of governance – national, provincial, and local. Defined as 'spheres', rather than 'levels', in the Constitution to highlight the 'distinctive yet interdependent and interrelated' nature in which the spheres operate (Oosthuizen & Thornhill, 2017),

the 'local' sphere is comprised in this case of both a District Municipality (Vhembe) and a Local Municipality (Musina) (Versteeg et al., 2009). Local government's developmental mandate is split between the two municipal structures, further problematising its implementation.

In addition, decentralisation has taken place within government departments in specific ways. Within the DoH, decentralisation has been in accordance with the *National Health Act* (61 of 2003) and *Schedule 4* of the *Constitution* (of 1996); while major health policy decision making resides with the national DoH, primary healthcare, hospitals, and most service provision falls under the mandate and control of the provincial government (McIntyre & Klugman, 2003). Primary healthcare, while a mandate of the provincial government is envisaged as being 'rendered under the auspices of district health councils' (Vhembe in this case), while local municipalities (Musina) are mandated to see to 'municipal health services', which 'includes aspects of environmental health care but does not specifically include primary health care' (Steytler & De Visser, 2007). The decentralisation of the DoH has not been without its problems, and has, at various points involved concern over the unnecessary provincialisation of primary healthcare in some cases (Versteeg et al., 2009) and the inadequate provincialisation of these services in others (*Independent Municipal and Allied Workers Union v President of the RSA, Case no. 3298/2006*; Steytler & De Visser, 2007).

Regardless of the extent to which the provincialisation of primary healthcare has taken place, the decentralisation of healthcare has created a serious policy problem. Although policy is made at a national or provincial level, it is infrequently and inadequately communicated to implementing staff at a provincial or local level respectively, which has led to low staff morale and frustration (McIntyre & Klugman, 2003). This is, more broadly, indicative of the limited attention paid to the 'software' of the South African health system (Gilson, 2003, 2005, 2006; Gilson et al., 2005). Workplace trust – 'respectful and fair treatment in the workplace (Gilson et al., 2005) – has not been prioritised by the DoH. Research within the South African health system has indicated that this lack of trust and attention to 'software' contributes to a broader environment in which accessing healthcare becomes more difficult for patients (Gilson, 2003, 2006; Gilson et al., 2005).

Within this context, it is imperative to investigate what it means to talk about policy making and how we conceptually understand policy processes within various spheres of governance. Particularly in a way which accounts for ideas, influence, and evidence,

without neglecting the ways in which different spheres of governance interact, aggravate, and mediate the policy process for each other. As such, I now return to my research questions.

These three sections exploring various findings in the data that have not been discussed in great detail in the papers contribute to a broader understanding of the context surrounding the interventions in Musina. As paper four (de Gruchy, submitted) argues, the findings discussed across the papers are at odds with current theories and frameworks of policy making in several respects. The following and final chapter will summarise this argument and the conceptual framework proposed in paper four, with support from this additional discussion.

9. Conclusion

9.1 Improving our understanding of policy processes in South Africa: A conceptual approach

As such, I return to my research question:

> Given the lack of locally-relevant policy frameworks, and the limited nature of both research on and responses to migration and health, can a case study of policy and programmatic responses to the health and wellbeing of migrant farm workers in Vhembe District, Limpopo inform a conceptual framework that is able to improve understandings of policy processes around migration and health in South Africa?

And objective 4:

> To be able to explain, conceptually, why policies are made or left un-made, and in so doing address the limitations of existing frameworks.

While much of this has been discussed in de Gruchy (submitted) [Paper four], in direct response to my research question I will now lay out a conceptual approach that I believe can improve our understanding of policy processes in South Africa.

As I argue in de Gruchy (submitted) [Paper four], there are four tensions between existing understandings of policy processes and this case study. The first concerns the temporal element in policy making. Most approaches acknowledge the need for a particular 'moment' to elicit a policy response, for example Kingdon's 'policy window' (2011). However, as this research shows, an improved understanding of the temporal aspect after this 'moment', in relation to implementation and sustainability, is needed in order to improve understandings of policy processes.

The issue of sustainability as such emerges as a second tension in respect to existing theories and frameworks. Existing theories and frameworks at a stretch acknowledge the importance of understanding implementation to form part of the policy process (Agyepong & Adjei, 2007; Béland & Ridde, 2016; Betts & Orchard, 2014; Howlett, 2018). However, as this research shows, given the presence of iNGOs, implementation is not the final stage of the process. Rather, it is the period during which the state takes over

and must sustain the interventions. Sustainability is a key theme in literature around iNGO intervention (Berlan & Bruno-van Vijfeijken, 2013; Cairney & Kapilashrami, 2014; de Gruchy & Kapilashrami, 2019). Given the reality of iNGO presence in LMICs, an improved understanding of sustainability as a part of the policy process is necessary as part of an improved understanding of policy processes per se.

This speaks to the third tension between the research and the existing theories – the presence of iNGOs in Low- and Middle-Income Countries (LMICs). Within existing theories and frameworks, these organisations are simply treated as yet another actor in the policy process. However, this case study shows that their presence in a local context also functions as an 'external perturbation', to borrow from the Advocacy Coalition Framework (ACF) (Jenkins-Smith et al., 2014). It is not only the 'crisis', but also the presence of iNGOs, that elicits a response from the state. In some cases, the state response can be to allow iNGOs or local NGOs to take on the role and responsibility of the state. A long-term example of one of the ways in which civil society have taken on a function of the state has been in response to community-based healthcare workers who, as noted in section 8.4.3, play a key role in the response to HIV, but are not incorporated into the public health system formally. Rather, community-based healthcare worker programmes remain in the hands of NGOs, with, at various points, financial support from the state.

Finally, theories tend to treat the state as responsive to policy windows. However, as this research clearly shows, while the 'crisis' in Musina and subsequent involvement of MSF and the IOM elicited a reaction from the state it was, at best, fleeting. The state, and its agenda, present as impenetrable and impervious to the realities in local municipalities, like Musina.

As such, I have developed a conceptual understanding of the policy process seen here that takes account of these tensions. While the exact context in which such responses are seen may change, as, for example, the NHI is implemented, I believe that the conceptual structure of this framework will remain applicable and relevant.

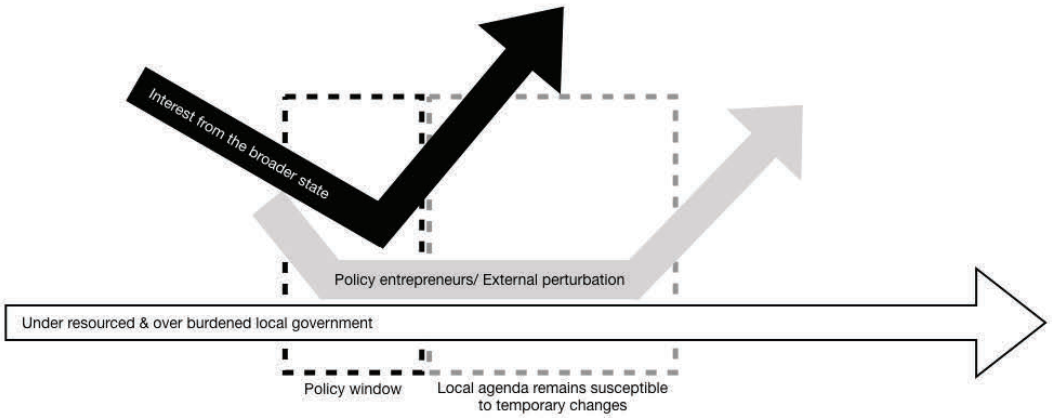

Figure 3: A conceptual understanding of the policy process in Musina

This figure captures what, I believe, are the various elements that result in responses to migration and health. What this figure highlights is the dependency of the development of responses on a moment that brings together iNGOs and broader state structures. It captures the reactive response of the state and iNGOs to particular moments, as well as the timebound nature of their interest in an area.

In addition, as I argue in de Gruchy (submitted) [Paper four], this way of the broader state and iNGOs responding to and interacting with local government emerges as a pattern when developments between 2012 and 2016 are also taken into account. The emerging pattern can be seen in Figure 4.

In 2012, Vhembe District was declared a priority district of the National Strategic Plan (NSP 2012 – 2016) and one of eleven districts within which the National Health Insurance (NHI) would be piloted. This once more elicited an interest from iNGOs, as funders such as PEPFAR announced their intention to fund health programming in the District, and support from the broader state. However, this kind of response is at odds with the development of sustainable health policies and programming that are able to improve the access that migrant farm workers, and other key populations, have to healthcare.

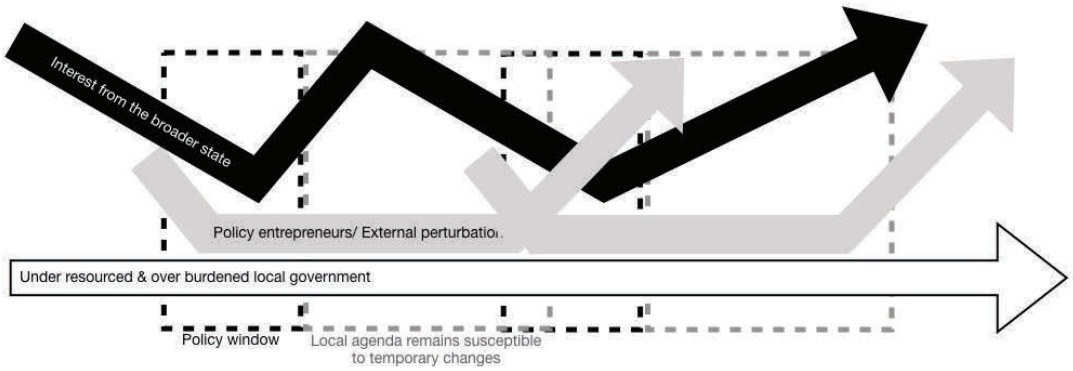

Figure 4: A longer-term view

If global health targets and local developmental mandates are to be met, a fundamentally different model is required. Within this context, calls for migration-aware policy and programmes simultaneously represent an example of a policy response that is not immediately forthcoming because there has been no acknowledgement that the status quo represents a crisis that requires a response *and* an example of what a radical restructuring of the current model of responding to migration and health could look like. Through a restructuring of the model of response, both social and political and material determinants would be reoriented to improve the long-term access that migrant and mobile individuals and communities would have to healthcare.

9.2 Lessons for future advocacy

I believe that this research suggests five directions within which advocacy could work to improve the access that migrant farm workers, as well as other key migrant and mobile populations, have to positive determinants of health.

Given the limited ways in which the decentralisation of policy making and the administration of the state has taken place, much agenda setting and policy making within South Africa remains within the national sphere (Landau & Singh, 2008; McIntyre & Klugman, 2003; Siddle & Koelble, 2013). In addition, as this research has shown, the ability of the DoH at a sub-district level to sustain the interventions it deems important is curtailed by limited support from the District, Provincial, and National health systems (de Gruchy, 2019; de Gruchy & Kapilashrami, 2019) [Papers three and two, respectively]. As such, the national DoH emerges as *the* key stakeholder in ensuring that policies and programming are migration-aware and mobility-competent, and consequently the site at which advocacy for migration-aware responses should occur. Given the current push to implement the NHI, regardless of

the poor outcomes of the pilot projects (Genesis et al., 2019) and the potential constitutional challenges it may face, including with regards to the rights that non-nationals will have to care (Johannesburg Migrant Health Forum, 2016), communicating the potential, as well as the challenges, of current models of intervention is crucial. Specifically, with regards to community-based programmes and iNGO-led interventions. The interventions detailed in this project are both examples of good practice and examples of the failure of the DoH to capitalise on community-based and local opportunities.

The second series of stakeholders with which efforts to improve policy and programme development must engage is local government. Although the National DoH is key, local government still has a developmental mandate and improving understandings and implications of this are crucial. Importantly, improved understandings of the opportunities that engaging with migration and health create for realising this mandate and improving health and wellbeing across municipalities and districts are needed (Landau & Singh, 2008; Vearey, 2010; Vearey, Modisenyane, et al., 2017).

Third, South Africa must be encouraged to work with the Southern African Development Community (SADC) to improve mechanisms for the movement of SADC nationals within the region. While this research has not explicitly looked at SADC, the lack of regional integration and the consequences thereof for the access that migrant and mobile communities have to healthcare have been highlighted throughout. Revisiting and implementing the 2009 *Draft Policy Framework for Population Mobility and Communicable Diseases in the SADC Region*, may go some way to improve access, and consequently health outcomes, for SADC nationals in South Africa.

In addition, as this research has shown, access to social determinants of health that would positively impact the health and wellbeing of migrant farm workers are limited due to the fragmented way in which this key population is engaged with by the state (de Gruchy & Vearey, in press) [Paper one]. Responses therefore need to overcome the siloed nature of governance in which occupational health and safety is exclusively the mandate of the DoL, but health the mandate of the DoH, for example. Instead, cross-sectoral responses must be advocate for and implemented. Two potential avenues that could be considered are the creation of a migration focal person within the DoH who would co-ordinate inter-departmental collaboration, and the development of a national migration and health policy, as in the case of Sri Lanka (International

Organization for Migration, 2013; Wickramage et al., 2017). While the former may result in many of the same problems as seen in gender mainstreaming in South Africa (Mannell, 2012), and the latter would probably necessitate working with the IOM, and, as such, making allowances for their agenda (Pécoud, 2018), they are two examples of potential starting points that could be considered.

Finally, this research suggests that the current model of non-state intervention by humanitarian and United Nations agencies, as well as funders and local civil society, creates problems of sustainability (de Gruchy & Kapilashrami, 2019) [paper two]. This research points to three questions with which iNGOs in particular must be encouraged to engage with in order to improve the ways in which they intervene in the South African context, as well as in other LMICs.

The primary question with which iNGOs must engage concerns the implications of responding to migration and health during moments of crisis, and linking the rights that migrants have to healthcare to such moments. As is suggested in de Gruchy and Kapilashrami (2019), this may undermine calls for proactive responses to migration and health, for example the development of migration-aware and mobility-competent policies and programming. A subsidiary of this, and second question, concerns agenda setting. As this research has shown, while the involvement of non-state actors shifts the state agenda, this shift is not necessarily long-lasting nor impactful and does not long outlive the crisis itself (de Gruchy, submitted) [paper four]. Additional ways of influencing state agenda and encouraging the state to engage with migration and health need to be investigated.

Finally, questions of programme integration and sustainability need to be explored. As this research shows, it is clear that the DoH is disinterested in actively maintaining and sustaining programmes, even if they are formally integrated within the system – as is the case with the Musina Model of Care (de Gruchy, 2019; de Gruchy & Kapilashrami, 2019) [Papers three and two respectively]. An acknowledgement of this reality and investigation of more robust mechanisms of integration and sustainability is necessary in order to improve the ability of programmes to withstand DoH neglect.

9.3 Future research & ways forward

What this research provides is a conceptual approach through which to understand why responses to key populations are limited and unsustainable. Future research can provide additional case studies, which may improve the understanding of policy and

programme development in South Africa, and other LMICs more generally. In addition, two areas of research that require additional attention are cross-border governance, and cross-provincial/district governance. This research has largely dealt with Musina and South Africa as the single point at the local and national spheres respectively. However, migration by its very nature links local and national contexts (Anthias, 2012; Fouron & Schiller, 2001). Linking rural and urban contexts and migration and modes of governance between the two, as well as across the South African border remains an important area of scholarship. Within Musina, cross-border forums exist specifically to develop bilateral responses to tuberculosis (TB) and HIV between South Africa and Zimbabwe. However, these appear limited by different national administrative structures and agendas. Whether mechanisms exist across districts or provinces between which migration and mobility are prevalent is unclear from this research. However, an improved understanding of the bilateral local and national space is important in the context of migration and a necessary area in which to conduct future research.

Since beginning this research, the developers of the NHI have continued to refuse to engage with the realities of migration, both internal and cross-border. In addition, increasing xenophobic rhetoric, legislative developments that would further securitise South Africa's borders, and suggestions that South Africa move to a policy of encampment have all been seen (Bornman, 2018, 2019b). Simultaneously, at the global level, several important policies have been developed and published since the inception of this research, including the Global Compact for Safe, Orderly and Regular Migration (GCM) and the World Health Organization's (WHO) Global Action Plan (GAP) for *Promoting the Health of Refugees and Migrants*. These developments, specifically the latter, provide important opportunities to advocate for migration-aware and mobility-competent health policies and programming (Gostin et al., 2019; Pant et al., 2019). However, they also serve to reassert the primacy of the nation state and its interests when engaging with migration and reify the role of non-state actors, including UN agencies, in responding to the health and wellbeing of migrants. As such, understanding the ways in which the South African state specifically but states more broadly approach issues of migration and health is increasingly imperative in order to develop both means of advocating for alternatives and ways of working around state responses.

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Appendix A: Information sheet

The Migration and Health Project Southern Africa (maHp)

The African Centre for Migration and Society (ACMS) has recently launched the Migration and Health Project Southern Africa (maHp). The Southern African region has both high rates of population mobility, and a high prevalence of communicable diseases, most notably HIV and tuberculosis. Whilst migration has been acknowledged as a central determinant of health, policy, programmatic, and health system responses to health and wellbeing within the region fail to engage with the movement of people.

Through a series of unique research and public engagement projects, maHp aims to explore and evaluate ways to generate and communicate knowledge in order to improve responses to migration, health, and well-being both within South Africa, and the region.

One of these projects is located within the Vhembe District (Musina Sub-District) and aims to generate a case study of the health and migration challenges facing the District, and to learn from current responses – such as the Vhembe District Migrant Health Forum (VDMHF) and the Musina Model of Care. An key focus area is to explore responses to the health and well-being of migrant farm workers in Vhembe.

Working with and through the VDMHF, we would like to invite you to partner with us in the research going forward. We invite you to share your thoughts about key areas that research should focus on, and in recommendations for how best we should engage with the migration and health community moving forward.

For more information on the broader maHp project and to get involved, please visit http://mahpsa.org/ or email Jo Vearey at jo.vearey@wits.ac.za

For information specifically relating to the Vhembe District migration and health project and to get involved in developing the research agenda moving forward, please contact Thea de Gruchy at theadegruchy@gmail.com

Migration and Health Project Southern Africa: A project of the African Centre for Migration and Society, University of the Witwatersrand
P.O. Box 76, Wits 2050, South Africa | **T**: +27 11 717 4033 | **F**: +27 11 717 4040 | **www.mahp.org**

Appendix B: Informed consent form

Consent Form

Title of research project: **The struggle over ideas: Investigating how policy processes affect the health and wellbeing of migrant farm worker in Vhembe District, Limpopo**

Principal Investigator: Thea de Gruchy, Doctoral Candidate and Researcher at the African Centre for Migration and Society

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Consent Form / Key informant interview

	Circle your response
I understand that I am under no obligation to take part in this project	**Yes / No**
I understand that I have the right to withdraw from this project at any stage	**Yes / No**
I understand that I have the right to not answer a particular question for whatever reason	**Yes / No**
I understand that I will be identified by both my name and position through the research	**Yes/ No**
I understand that this research is for academic purposes, but that through publication my contribution will be made available to the public	**Yes/ No**
I have read/been read this consent form and the information it contains and had the opportunity to ask questions about them	**Yes / No**
The researcher has explained to me that the tapes will be transcribed (typed out) and used only for the purposes of this study	**Yes / No**
I agree to be interviewed for this research project	**Yes / No**
I agree to my responses being used for research	**Yes / No**
I give consent for my name to be used in the final research report	**Yes / No**
I give consent to be audio taped during the interviews	**Yes / No** **Signature:** _____

PARTICIPANT:		
_____	_____	_____
Printed Name	Signature of Participant	Date

Appendix C: Example of a key informant interview guide

Interview guide for Community Health Workers and change agents

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Professional details

1. Can you tell me how long you've spent on the farm?
2. What work do you do on the farm?
3. How is that work structured?
4. Have you worked on other farms in the area?
5. Have you always lived in this area?
6. Whereabouts are you from?

CHW/ change agent

7. When did you become a CHW/ change agent?
8. Why did you decide to become a CHW/ change agent?
9. What was the process of becoming a CHW/ change agent?
10. What are your duties as a CHW/ change agent?
11. What support do you get in these duties?
12. Do you have regular training?
13. Do you have a support group for change agents?
14. Do you get any support in these duties from the farm?
15. What are the biggest differences between what you do and what CHW/ change agents do?

Interventions on the farm

16. What programs/ initiatives are there on the farm? Including mobile clinics, sport programs, creative programs, religious programs?
17. Who started these?
18. When were they started?
19. Why were they started? And have they achieved this aim?

20. If they were at the farm before 2011 – what was it like on the farm before the change agents/ CHWs and mobile clinics?
21. How did you access health care?
22. How have things changed since these initiatives started?

Health on the farms

23. What are some of the biggest health concerns that farm workers have?
24. What are some of the biggest occupational health and safety issues?
25. What are some of the biggest challenges that farm workers have in accessing health care?
26. Has the farm tried to help with this?
27. Have the mobile clinics helped?
28. Do you think that having CHWs and change agents has helped?
29. Are their different challenges when temporary workers join for the harvest?

Farm details

30. How many permanent members of staff are there on the farm?
31. How many temporary members of staff are there on the farm this season?
32. How is the compound structured? Are there different sections for permanent and temporary staff?
33. How many of these do you think are Zimbabwean? And South Africa?

Appendix D: Clearance Certificate from Wits HREC (Non-medical)

Research Office

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

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H16/08/10**
PROJECT TITLE	The struggle over ideas: Investigating the making and effects of policy around migration and health for migrant farm workers in the agricultural sector in Vhembe
INVESTIGATOR(S)	Miss T de Gruchy
SCHOOL/DEPARTMENT	Social Science/
DATE CONSIDERED	19 August 2019
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	02 October 2019

DATE 03 October 2016 **CHAIRPERSON** J. Burns
pp (Professor J Knight)

cc: Supervisor : Professor J Vearey

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

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

Signature T de Gruchy Date 04 / 10 / 2016

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES