

**MIGRATION AND HEALTH: EXPLORING THE EXPERIENCES OF AFRICAN
IMMIGRANT CAR GUARDS IN DURBAN, KWAZULU-NATAL**

By

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ABSTRACT

Background: Ensuring adequate provision of healthcare for immigrants remains a global challenge, and it is thought that understanding the complexities that immigrants encounter when seeking health care will improve their access to healthcare.

Aim: This study aimed to explore the experiences of African-immigrant car guards working in eThekweni, South Africa, in accessing healthcare services.

Methodology: The data for the study was collected through the use of in-depth interviews with 16 purposively-selected respondents who are African-immigrant car guards. The data was analysed by making use of the thematic analysis approach.

Results: The findings are that most of the respondents have a good perception of the South African health system. However, the language barrier is still a major challenge for many immigrants when utilising health services. The coping mechanism adopted by the respondents is remaining calm, regardless of how frustrated they become as a result of the language barrier. Male respondents commonly use over the counter medication from pharmacies to avoid long lines and the time consumed at clinics. Respondents who had higher levels of education tend to be better informed of healthcare services available to them.

Conclusion: Future advocacy campaigns pitching for a policy shift should focus more on ensuring that immigrants become fully aware of information pertaining to healthcare facilities and services available to them.

DECLARATION

I, Snegugu Lerato Mchunu, declare that the research reported in this dissertation is my own work, except where otherwise indicated. All citations, references and borrowed ideas have been duly acknowledged. This dissertation has not been submitted in any other form for any degree or examination in any other University.

The research was conducted between June 2014 and August 2015 under the supervision of Dr Kerry Vermaak. The opinions expressed and conclusions presented are those of the author alone.

Signed (candidate):

Submitted in partial fulfilment of the requirements for the degree of Masters of Population Studies in the Graduate Programme of the School of Built Environment and Development Studies, University of KwaZulu-Natal, Durban, South Africa.

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DEDICATION

I dedicate this thesis to my son Esihle. You may be only four years old at the moment however, in the years to come you will have a better understanding of life. I write these words to demonstrate that if you put your mind to something, anything is possible – hard work pays off. I want to be a good example to you. Hence; I aim to lead by example. Mommy loves you dearly. I furthermore dedicate this research to both my parents, brothers, cousins and uncle. Without your sacrifices and support it would have been much harder to make this a reality. I am forever grateful for having you all in my life.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARVs	Antiretrovirals
CoRMSA	Consortium for Refugees and Migrants in South Africa
DOH	Department of Health
DoE	Department of Education
DHA	Department of Home Affairs
DRC	Democratic Republic of Congo
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IBBSS	Integrated Biological and Behavioural Surveillance Survey
ICESCR	International Covenant on Economic, Social and Cultural Rights
IOM	International Organization for Migration
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organisation
MPS	Migrants with Precarious Status
PHC	Primary Health Care
SADC	Southern African Development Community
SAMP	Southern African Migration Programme
SAPS	South African Police Services
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
WHA	World Health Assembly
WHO	World Health Organization

TERMS AND DEFINITIONS

Migration: A form of geographic or spatial mobility of persons, between clearly defined geographic units, involving a change of usual residence (Siegel, 2011, p976).

International migration: It is the crossing of national boundaries (Siegel, 2011, p976).

Immigrant: A person who is entering a country from another to take up new residence (Siegel, 2011, p977).

Refugee: A person who is residing outside the country of his or her origin due to fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion (Siegel, 2011, p977).

Asylum seeker: A person seeking admission into a country as a refugee and awaiting a decision on their application for refugee status under relevant international and national instruments (IOM Glossary on Migration, International Migration Law, 2004, p2).

Migrant: The term migrant applies to persons or members of a family moving to another country or region to better material or social conditions, with the intention of improving their prospects (IOM Glossary on Migration, International Migration Law, 2004, p2).

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CHAPTER 1: INTRODUCTION

1.1 Background and problem statement

Migration has been identified as a social factor of health, needful of suitable policy and programme responses (Anarfi, 2005; MacPherson and Gushulak, 2001). In many marginalised populations, factors outside of the health sector largely determine the health of migrants. Migrants are exposed to experiences and conditions during the process of migrating that place their physical, mental and social well-being at danger. (International Organisation for Migration, 2004). Even migrants who possess legal documentation may experience challenges accessing healthcare services as a result of language barriers. Those who do not have the correct paperwork may have undergone dangerous journeys. They may not seek healthcare in the host country, leaving the possibility of undetected or untreated diseases acquired during their journey. Furthermore, migrants are subjected to discrimination, stigmatisation and xenophobia (World Health Organization, 2008). These factors result in migrants experiencing social exclusion and social inequalities with regards to the access of healthcare, education, employment, social benefits received by citizens and social networks. The obtainability, convenience, appropriateness and quality of services in the host country largely determine the health of the migrants. In addition, multiple influences – including legal status as well as social, cultural, structural, language, gender, economic and geographical factors – determine the health of migrants (Davies, Besten and Frattini, 2009, p2).

Recently, migration and health have received renewed attention through the 2008 World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (Vearey, 2012, p18). This was prompted by migration being identified as a megatrend in the 21st century (WHA, 2008). Furthermore, this megatrend is occurring in societies that have become more culturally and ethnically diverse. This change has presented new challenges for health systems, which are required to adjust in order for them to remain appropriately responsive (WHA, 2008). The WHA resolution called upon member states to ensure the health of migrant populations, through a range of actions including: promoting migrant-sensitive health policies; promoting equitable access to health promotion, disease prevention and care for migrants; and promoting bilateral and multilateral cooperation on migrants' health among countries involved in the migratory process (Vearey, 2012, p18).

However, one must acknowledge that this high-level strategy commitment was made only recently, several challenges to guaranteeing the health of international migrant populations remain (AIDS and Rights Alliance for Southern Africa, 2008; Amon and Todrys, 2009). Within the South African region, several negative assumptions continue to be associated with the movement of people with poor health. Furthermore, international migrants are associated with placing an additional burden on the existing public health systems of destination countries (Southern African HIV Clinicians Society and United Nations High Commissioner for Refugees (UNHCR), 2007). In the past, cross-border migration was linked to the spread of disease, and the ongoing assumptions of today mirror this (Harper and Raman, 2008). Worldwide, and specifically within the Southern African Development Community (SADC) region, “foreigners” are repeatedly accused by governments for introducing and spreading disease (Amon and Todrys, 2008; Harper and Raman, 2008). According to Grove and Zwi (2006), the resultant downgrading of non-citizen clusters has resulted to health becoming conflated with “the politics of citizenship” – as an outcome of this, many non-citizens have been denied access to healthcare (Harper and Raman, 2008,p18).

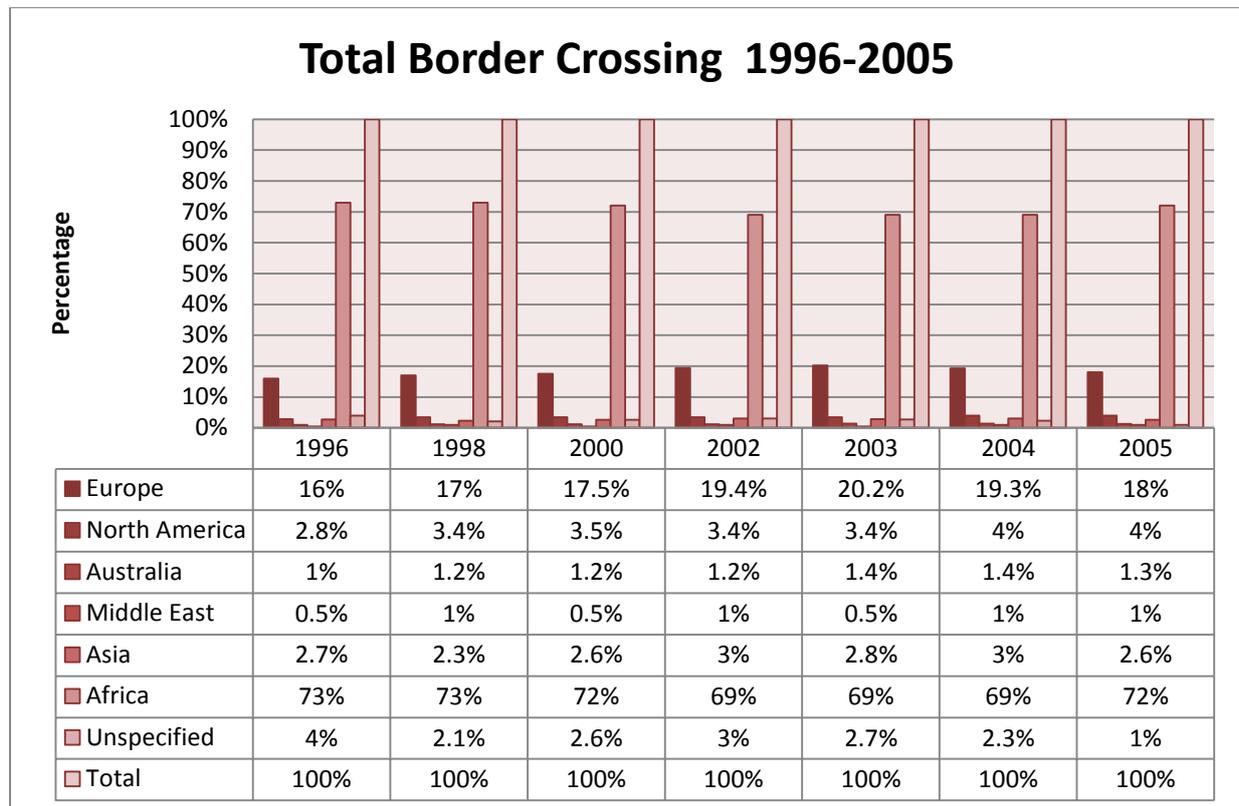
Recent research has indicated that African immigrants in South Africa continue to face difficulties when seeking health care due to such notions (Vearey, 2008). This research has focused on the access to antiretrovirals (ARVs) for African immigrants based in Johannesburg, with the focus on one gender (Vearey, 2011). However, little research provides insight into the experiences and perceptions surrounding the accessibility of health care by both male and female African immigrants as they encounter different challenges. This research seeks to explore the experiences and perspectives of immigrants, employed in the informal sector, in accessing healthcare services in Durban, a major city in the province of KwaZulu-Natal, South Africa.

1.2 Migration to South Africa

The Neoclassical Macro theory is one of the oldest theories that has been used to explain labour migration and its contribution to economic development (Lee, 1966). The theory attributes international migration largely to the geographic differences in the supply and demand for labour in different countries.

This theory may be useful in explaining migration to South Africa from other African countries, as it has been noted that better economic opportunities exist in South Africa. The increase of African immigrants can be strongly associated with increased economic stability (HSRC, 2006). Vulnerable working class groups are even able to generate an income in the informal sector. The table below demonstrates how the number of immigrants has increased over the years. It identifies the areas that immigrants are originally from, and the outflow of migrants that has taken place over the years. It is evident that most of the immigrants that are in South Africa have come from African countries, and the number has gradually increased over the years (Department of Home Affairs (DHA), 2006).

Graph 1: Total Border crossing 1996 – 2005



Source: South African Tourism Strategic Research Unit, 2006 Annual Tourism Report

Apart from the economic constraints encountered in many African countries, many Africans have emigrated due to socio-political issues. This can be seen in countries such as the Democratic Republic of Congo (DRC) and Rwanda where many of their citizens have migrated to South Africa in order to protect their lives, as well as those of their families (Crush, Williams and Peberdy, 2005). Even after years of staying in South Africa, many of these foreigners still face numerous challenges obtaining permanent paperwork that would give them state recognition in South Africa (DHA, 2006). Many of them still depend on refugee camps or non-profit organisations (NGOs) for support.

1.3 Primary Healthcare in South Africa

According to the World Health Organization (WHO), primary health care (PHC) is seen as necessary healthcare (2008). This health care is achieved by practical, scientifically-sound and socially-acceptable methods and technology. PHC has to be universally accessible to

everyone in the community, enabling their full participation, at an affordable cost. It further has to ensure that self-reliance and self-determination is established in every individual (WHO, 2008).

The provision of PHC can be seen simply as a basic need. It is to ensure that universal access to appropriate, efficient, effective and quality health services in order to improve and promote people's health exists (Ndhambi, 2013, p3). PHC places much emphasis on the healthcare of all people, and their health needs, thereby reinforcing and strengthening their capacity to shape their own lives.

PHC in South Africa varies from the highly specialised, hi-tech services that are accessible in both the public and private sector, to free PHC that is offered by the state. However, resources within the public sector of South Africa have been stretched very thin and are unequally distributed. The public sector has been placed under tremendous pressure as it has to deliver services for 80% of the population, while the state is only able to contribute 40% of all its expenditure to health (Department of Health, 2007, np). The private sector caters for those within the middle and upper class who have medical schemes. It is in this sector that more health professionals prefer to work.

1.3.1 Primary health care priorities – South African context

According to Stack and Hlela (2002), healthcare priorities should be sustainable and focused on the improvement of access to the healthcare system. They should, further, be accessible for free to children and pregnant women. Healthcare services should therefore be scheduled and structured in a manner that resources can be effectively utilised to ensure that basic health care is available to all South Africans and giving urgency to vulnerable groups.

As a matter of priority, according to Ndhambi (2013, p10), the following health concerns should be targeted by a comprehensive, national primary-healthcare service:

- Child health, infectious diseases, and immunisation;
- Sexually transmitted diseases and HIV/AIDS;
- Tuberculosis (TB);
- Reproductive health: Antenatal, prenatal, postnatal care, and family planning;

- Mental health;
- The promotion of adequate nutrition;
- Rehabilitation; and
- Oral health.

1.4 Policy environment of health care for immigrants in South Africa

The right to life is a vital human right upheld worldwide in national constitutions, as well as in international human-rights treaties. Regardless of this, a large number of individuals find themselves denied access to medical treatment. It has been reported that for many, their status of being a foreigner has contributed to them being denied health care in South Africa (Zihindula, Meyer-Weitz and Akintola, 2015). According to the Universal Declaration of Human Rights, section 25, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” (Glendon, 1997,p1180).Section 27 of the Constitution of South Africa states that everyone within the borders of the country has the right to access health care, including refugees, asylum seekers as well as undocumented migrants (Moyo, 2010). It further states that no one should be refused medical care, including reproductive health and emergency medical care within its territory.

1.5 Objectives

The aim of this study is to explore the experiences and perspectives of immigrants employed in the informal sector, with regard to accessing health care services in Durban, South Africa.

The objectives include:

1. To explore their experiences in accessing healthcare services;
2. To assess the factors that hinder their access to healthcare services;
3. To assess their awareness of what health services are available to them.

1.6 Key research questions

1. How accessible are health facilities for African immigrants in the informal sector?
2. What has been their experience of utilising health services?
3. How would they describe their encounter with health providers?

4. What difficulties do they face in accessing healthcare services?
5. How do they deal and cope with the barriers to accessing health services?

1.7 Theoretical framework

This study looks at African immigrants and their access to healthcare services in Durban, South Africa. The principle theoretical framework that will inform this study is the Andersen (1968) model of healthcare utilization. The model has three categories which have been identified as determinants that would drive an individual to utilization of healthcare services. According to Andersen (1968), there are predisposing characteristics that influence an individual's inclination to use healthcare services. He further states that the use of healthcare services by an individual is greatly influenced by factors such as demographics, ones position within social structures and the belief that the available healthcare services have numerous benefits. Furthermore, variables such as age, sex, family size, ethnicity and social class, were identified as factors that could potentially influence the position of a family within a society, their way of living and on both physical and social environments.

The framework outlines that an individual who believes that the healthcare services are useful, with regards to the treatment that will be received, will be most likely to use the available services. These are known as 'enabling' characteristics.

The framework also states that there are need-based characteristics that will determine the use of healthcare services by an individual. As a result of this, 'need' factors been included in the model. Andersen speaks of two types of need factors. The first need factor being related to illness variables and the second to response variables (Andersen, 1968, p5). Not only must the individual or family identify that there is an illness, but they must also respond in a correct manner that will enable them to access the required services.

These responses would be determined by the assets found within the family and the community. Family assets encompass of both economic status and the areas in which one resides. Community assets incorporate how accessible healthcare facilities are, and the availability of the healthcare professionals. This also requires that the individual or family sees a need for health services to be rendered (Wolinsky, 1988).

The research that has been done by Vearey (2008) has highlighted that being a foreigner in a new country has often placed many at the disadvantage of being denied access to healthcare services. Many factors have resulted in this outcome but much emphasis can be placed on the politics of citizenship. With the knowledge of the numerous challenges immigrants encounter during their accessing of healthcare services, the study employs this framework to find out what has determined and driven individual use of healthcare services, notwithstanding the challenges. This has been done by focusing more attention on the three categories outlined in Anderson’s theoretical framework. Making use of the behavioural model in this manner enabled inequalities in the utilisation of primary healthcare services by ethnicity and age cohort to be explored. This illustrates individual levels of needs and beliefs in the health system as a driving factor of individuals accessing healthcare. The framework provided the researcher the opportunity to add to the body of knowledge on the determinants that drive individuals to accessing healthcare services.

Figure 1: Andersen’s Behavioural Model of Health Services Utilization



Source: Wolinsky, F. (1988).

1.8 Structure of the dissertation

The second chapter provides a review of literature on immigrants with regards to healthcare issues. The third chapter outlines the research methodology that has been used in this study. This includes the study design, methods of data collection and selection of participants, data-collection sites, individual interviews, procedure, trustworthiness, data analysis and ethical

considerations, concluding with a summary of the whole chapter. The fourth chapter presents the findings of the in-depth interviews. Lastly, the fifth chapter discusses the findings of the study, the recommendations and final conclusion.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The chapter begins with a brief overview of refugees and asylum seekers in Southern Africa, the history of cross-border migration in South Africa, South Africa's response to refugees, and the profile of migrants in South Africa. It outlines the availability of social services for immigrants, the social wellbeing of immigrants, and HIV/AIDS and migrants. The chapter reviews literature on African immigrants and their understanding of healthcare services, and the barriers associated with accessing healthcare services. It will further look into literature on how migrants in other countries have been treated, when it comes to issues of healthcare.

2.2 Overview of refugees and asylum seekers in Southern Africa

The Southern African region hosts approximately half a million asylum seekers, stateless persons, returnees and internally displaced people (UNHCR Global Report, 2013). According to the UNHCR Global Report (2013), there were 136 000 refugees and 278 000 asylum seekers in Southern Africa at the end of 2013. Governments in these regions have expressed reservations related to national security regarding trafficking, human smuggling and the abuse of the asylum system. Thus a need for stricter border controls has been identified. Countries in this sub region are part of the 1951 Refugee Convention and 1969 Organisation of African Unity (OAU) Convention (UNHCR Global Report, 2013). As well as this decreased tolerance of migrants at official level, there seems to be greater hostility on the ground towards migrants. Attacks on foreigner-owned businesses in South Africa have been witnessed recently, and simultaneously public and official support for refugees has weakened in Angola, Botswana and Malawi (UNHCR Global Appeal, 2015).

2.3 The history of international migration in South Africa

According to Siegel (2011), migration is a form of geographic or spatial mobility involving a change of usual residence between clearly defined geographic units and national boundaries. Some changes of residence, however, are temporary or short term, and do not involve changes in usual residence; therefore these are commonly excluded from the statistics on migration (Siegel, 2011). International migration, by contrast, involves the crossing of national boundaries. The person involved in such a move is simultaneously called an

emigrant (from the perspective of his/her country of origin) and an immigrant (when viewed from the country of destination) (Siegel, 2011).

Immigrants can legally move into South Africa as permanent residents, temporary residents, or as refugees, once the required documentation has been received. During the apartheid era, the Aliens Control Act of 1991 was used as policy that guided issues of migration into the country. It regulated migration and immigrants in the country until it was replaced by the Immigration Act of 2002 (Dobson and Crush, 2004). Prior to 1994, South Africa did not have any legislation that was specific to refugees. The challenge of obtaining data that captures the precise number of foreigners coming into the country has, since 1994, been exacerbated by the pool of immigrants that come into the country undocumented (Dobson and Crush, 2004).

After 1994, there was an increase in the number of visitors coming into the country on business. A decline has been identified in the number of people who have moved in as contract workers as well as those who move in as permanent residents since 2000 (HSRC, 2006). Researchers in the field of migration have stated that the media has placed emphasis on the number of illegal migrants, mainly from other African countries to South Africa. It is often the case that the media perception seems to be that African immigrants in South Africa do not have valid documentation that grants them the right to stay in the country. However, the Human Sciences Research Council (HSRC) observes that existing data has shown that the majority of African migrants and refugees have the documents required for them to be within the country legally (HSRC, 2006).

It must be noted that there is no precise way of knowing the specific number of permanent residents in the country at any given time. The immigration policies and practices exercised in South Africa before 1994 contributed to the low number of applicants approved for immigration. However, after the new policy of 2002 was introduced, there was an increase in the numbers of approved applicants (Dobson and Crush, 2004). By 2005, more than half of the newly-granted permanent-residence permits were issued to those who originated from other African countries. Around 266,000 Africans were estimated to have moved into the country during the period of 1995, 1996 and 1999-2000 (DHA, 2006).

Most asylum seekers that have migrated into the country have been from African or Asian countries. Between the period of 1994 and 2001, the DHA received approximately 150,000 applications from asylum seekers (DHA, 2006). Out of this number 26,900 were granted refugee status. In 2006 (the latest year for which data was available by country) an “estimated

53,363 asylum claims were made, the highest ever number” (DHA, 2006, p14). Of these claims males constituted 78%, women 20% and children only 2% (DHA, 2006).

The DHA, in response to the increase in numbers of asylum seekers wanting to come into the country, formulated a project that attempted to reduce the number of people being granted refugee permits. Of the 111,157 outstanding claims in the backlog project at the beginning of 2006, 29,325 were finalized, leaving a balance of 81,832 people with the status of asylum seekers while awaited for decisions on their entitlements to refugee status (DHA, 2006, p15).

Almost three quarters (74%) of these refugees were identified as originating from an African country. The largest number of claims for refugee status between 1994 and 2001 was from individuals originating in Angola, Burundi, the DRC, and Somalia. A substantial number of applicants were from countries such as Cameroon, Nigeria, Senegal, India and Pakistan (DHA, 2006, p16). However, the high rejection rates for applications from these countries, proposes that the DHA deemed that these were economic migrants rather than refugees. More acceptances were given to refugees from the DRC, Somalia, Rwanda and Angola, while the bulk of applicants from other African countries were declined (DHA, 2006). Data for 2006 demonstrates a variation in the countries of origin of applicants for asylum over the period of 1994-2001 (DHA, 2006, p16). Most notable is that Zimbabwe was the largest source of asylum claims in 2006, comprising over a third of all claims (18,973). Also new to the list as a significant source of asylum claims was Malawi with 6,377 claims (12%) (DHA, 2006, p16). Other countries contributing to the bulk of applications were the DRC, Ethiopia, Bangladesh and Somalia (DHA, 2006). The table below demonstrates clearly which countries regard SA as a sought-after destination for asylum seekers.

Table 1: Refugee applications by country of origin, 2006

	Applications	
	Number	%
Zimbabwe	18 973	35.4
Malawi	6377	11.9
DRC	5582	10.5
Ethiopia	3916	7.3
Bangladesh	3074	5.8
Somalia	3024	5.7
Tanzania	1838	3.4
Pakistan	1363	2.6
Congo (Brazzaville)	1201	2.3
India	1175	2.2
Others	6832	12.8
Total	53361	100

Source: 2006 Annual report on asylum statistics (January to December) (DHA, 2007)

2.4 Refugee legislation in South Africa

According to Peberdy (2009), during the apartheid era refugees and asylum seekers were not welcomed into South Africa. However, White immigrants from decolonising countries were accepted regardless of whether or not they met the terms and conditions of the immigration legislation (Peberdy, 2009). Literature suggests that Whites who migrated from Mozambique were welcomed into South Africa and given permanent residence (Peberdy, 2009). In 1993, the apartheid government came into agreement with the United Nations High Commissioner for Refugees (UNHCR). As of that date, until the passing of the refugee legislation under the Aliens Control Act of 1991, new refugees and asylum seekers were permitted different permits under this act (UNHCR, 1992). It was post 1994 when South Africa became a signatory to the United Nations' 1951 Convention of the Status of Refugees and its 1967 Protocol, as well as the 1969 Organization of African Unity's (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa (UNHCR, 1992, p16).

The first refugee security regulation of South Africa took less time to develop than that of its new immigration legislation. The 1997 Green Paper required that there be a specific framework developed for refugee protection (Peberdy, 2009). In 1998, the Refugee Act No. 130 was passed in South Africa (Peberdy, 2009). However, it was not enforced until 2000;

this was due to some disputations over its provisions, and accompanying legislations. In 2008, further amendments were made by the Refugees Amendment Act (No. 33) (Peberdy, 2009). These amendments resulted in procedural changes to the refugee determination procedures and aligned the process closely to international instrument (Peberdy, 2009, p23). The administration of the Act was identified as being problematic since it raised questions regarding the obligation of the government to its refugee regimen (Peberdy, 2009). Asylum seekers were subjected to having to wait for years for their refugee application status to be settled.

The period during which asylum seekers await an outcome of their adjudication, however, left the system at risk of being abused. Nevertheless, the Act provides security to asylum seekers in South Africa, as they and refugees are entitled to work study and access medical treatment as if they are South African citizens.

2.5 Profile of migrants in South Africa

This study focuses more on immigrants from the DRC and Rwanda, as the participants in this study included these two groups. The section below will briefly discuss the cause of the refugee crisis, demographics of the migrants, their country of origin and the push and pull factors driving them into South Africa.

2.5.1 Causes of the refugee crises

The DRC is known for its long history of armed conflict and unrest. This has greatly contributed to its ongoing refugee crisis. According to the Cultural Orientation Resource (COR) Center (2012, p1), more than 2.4 million Congolese were internally exiled and more than 460,000 had pursued asylum in neighbouring countries by the end of 2012 (COR, 2012, p1). This conflict was triggered in 1996 when the DRC was invaded by Rwanda in the wake of the Hutu genocide that occurred in 1994. This resulted in the first Congo war, when President Mobutu Sese Seko was dethroned and replaced by Laurent Desire Kabila. At the start of 1998, Kabila indicated that Rwanda was exploiting the minerals of the DRC (Hochschild, 2011). Kabila was supported by Angola, Namibia and Zimbabwe in the efforts to drive Rwandan forces out of the DRC. In July 1999, the Lusaka Ceasefire Agreement was set in motion with an attempt to end the hostilities between the different countries. This agreement was signed by Angola, the DRC, Namibia, Rwanda, and Uganda, as well as

Zimbabwe. Regardless of this effort, violence in the DRC continued and resulted in the Second Congo War, which is also known as the “African World War” because of the several countries involved in the conflict (Hochschild, 2011).

In spite of a peace accord that was signed in 2003 between Uganda and the DRC, unrest between the North and South provinces still plagued the eastern DRC. The central government as well as armed groups have continued to fight amongst themselves for control of the region and its rich resources. Thus, many civilians from the DRC have been forced to take refuge in the DRC’s neighbouring countries. The largest number has emigrated to Rwanda (32%), with the balance of refugees destined for Uganda (25%), Burundi (7%), Tanzania (5%) and South Africa. South Africa, with 3 % of the DRC’s refugees, has the lowest percentage of refugees compared with countries that border the DRC (Hochschild, 2011). The next section will provide a brief background on the Resettlement Support Centre (RSC) Africa that has assisted thousands of refugees from the DRC resettle out of unsafe neighbouring asylum countries.

2.5.2 Resettlement Support Centre Africa

RSC Africa started in 1990 in Nairobi and Kenya, assisting thousands of refugees across the continent (COR Center, 2012). Refugees in camps and in urban locations throughout Africa have been assisted. The RSC Africa has been administered by the Church World Service (CWS) as part of the agreement with the USA government whereby RSC Africa is responsible for processing refugee applications from 49 countries in sub-Saharan Africa (COR Center, 2012). The next section will discuss the basic demographics of the Congolese. It will further make reference to the caseload of DRC refugees in the USA and their resettlement experience there. The USA has been used as an example as the RSC Africa in Nairobi and Kenya has helped 200,000 refugees move to the USA since 1990 (Cultural Orientation Resource Center, 2012); furthermore, there is no available information in South Africa on this matter.

2.5.3 Demographic Characteristics

2.5.3.1 Age and gender

The Congolese caseload has been known to be relatively young. More than half (55%) of it comprises individuals under the age of 18, and almost a fifth (18%) are between the ages of 18-25 years (U.S. Department of State (DoS), 2012). Only a quarter of the caseload is identified as being over 25 years, while 3% of the Congolese population is 50 years and older (U.S. DoS, 2012). There is a slightly higher percentage of females (51%) than males (49%) in the caseload (U.S. DoS, 2012).

2.5.3.2 Occupational background

The skills and experience that the refugees hold varies tremendously. The USA caseload was made up of farmers, herders and unskilled workers from the rural areas. Others, who possessed professional skills, were typically from the urban areas (U.S. DoS, 2012). The most common professions among these were teachers, social/community workers and office-work related jobs. Women commonly had previously worked as small traders, selling clothes, food and other household goods. This population is one that can be regarded as diverse in terms of work experience and skills, and shares a strong desire to succeed economically in its host countries.

2.5.3.3 Education, Literacy and English Proficiency

Self-reported data, collected during refugee processing in the USA, found that almost all individuals who were over the age of 18 reported having had some formal education. One third reported having had some primary schooling and a little more than half reported intermediate, secondary or technical education (U.S. DoS Bureau of Population, Refugees, and Migration, Office of Admissions, Refugee Processing Centre, 2014, p10). The level of education of those who reported having had pre-university, university level or professional schooling comprised a similar percentage to that of the DRC's national average of five % (U.S. DoS et al., 2014). Amongst those aged 18 and over, almost 20 % reported being unable to read or write. This indicates that some of those individuals who attended school did not learn how to read and write. U.S. DoS et al., (2014) state that from what is known about the schooling attendance in the DRC, a great pool of those who are unable to read and write are females. Over half (59%) of the Congolese from the caseload were found to be unable to

speak, read or write English. Only 29 % reported knowing how to speak English, with a smaller proportion claiming to be able to read and write in English (U.S DoS et al., 2014). Having such a low percentage of English-speaking Congolese suggests that communicating one's challenges is likely to be a major problem in an area where the predominant language spoken is English. The language barrier would serve as an obstacle even when seeking appropriate healthcare services. Furthermore, not being able to read would be a limitation in terms of reading one's prescribed medication dosage and so on.

2.5.3.4 Health Status

As a result of the prolonged conflict in the DRC, most of the refugees have suffered from a combination of physical and psychological health-related issues. The psychological health issues are invariably linked with the trauma associated with the violence that most of the refugees have either been victims of, or witnessed. Sexual and gender-based violence (SGBV) has been commonly reported in the DRC. Higher percentages of women are reported as survivors of such violence (Peterman, Palermo and Bredenkamp, 2011), although domestic-service providers have reported that male victims of SGBV are not unknown (U.S. Department of State et al., 2014).

The most common medical conditions amongst refugees, according to the RSC Africa, include TB, hypertension, Human Immunodeficiency Virus (HIV), vision problems as well as heart disease. Furthermore, there may be an under reporting of less severe chronic conditions, for instance arthritis and back problems; these may mostly refer to the population that is familiar with conditions of daily physical hardship (Peterman, Palermo and Bredenkamp, 2012).

2.5.3.5 Religion

From the USA Congolese-refugee caseload it was found that 96% of the refugees were Christians (U.S. DoS et al., 2012). Of these, 80% were Protestant. However, most of the Christians in the DRC have been identified as being Catholic (U.S. DoS et al., 2012). Amongst the other denominations were also Pentecostals and Seventh Day Adventists. It is evident that religion is of great importance in the lives of the general population of the DRC and refugees in particular. Religion is seen as something which offers refuge, great comfort,

peace, as well as solutions to personal problems. Thus, religious leaders are of great importance to the DRC population, and in refugees' lives.

2.5.3.6 Healthcare beliefs and practices

The Congolese culture is one that is generally accepting of Western medicine. Even in secluded areas of the country, Western medicine is considered to be effective. The power of prayer is greatly believed in by Christians when it comes to curing illness (Ziemke, nd). Furthermore, the practice of traditional medicine is seen as complementary to Western medicine by those who may not be able to afford modern health care. A traditional healer in this case would be one who makes use of plants with medicinal properties to treat diseases.

It was evident from their responses that the refugees had little knowledge of Western concepts of mental illness, as no tradition of formal mental-health counselling was known within their culture. Research found that the use of therapeutic practice style (the use of therapy to address problems of a psychological nature) was an unfamiliar notion for Congolese, as it was seen as uncustomary to confide in a stranger (Ziemke, nd). The applied method that the Congolese have used to deal with past trauma or any hardship includes keeping busy, continuing with one's life and not dwelling on past experiences. Thus, depression is considered culturally not acceptable and suicide is not common.

2.6 Conditions in first asylum countries

Conditions for refugees in countries that they take refuge in have been known to vary by country and within countries. However, in most cases these have been very harsh, unhealthy and unsafe (U.S Department et al., 2014). Uganda hosts the prime population for refugees from the DRC. On one hand, these refugees live in similar rural settlements to those of the DRC, with small plots for farming. What poses a great challenge for women in particular, is having to walk extensive distances in order to get necessities such as water and wood (U.S Department of State et al., 2014). This increases their vulnerability and exposes women to the widespread problem of being victims of SGBV. Job opportunities are also very limited.

On the other hand, DRC refugees in Rwanda have been mostly restricted to living within the camp area. This has limited their exposure to education, work opportunities and recreation, and has contributed to the social breakdown in social order (U.S Department of State et al., 2014). Ugandan, Rwandan and Tanzanian camps do offer free primary education. However,

secondary education is limited. Furthermore in Tanzania, work, selling, trading of goods and the cultivation of land is tremendously limited (U.S Department of State et al., 2014). Services relating to mental health are particularly limited by the capacity of service providers to address the enormity of the problem, even though funds from the State Department's Bureau of Population, Refugees and Migration are available. Even when it comes to the South African context immigrants have faced a number of challenges.

2.7 Access to sanitation, housing and banking

According to Misago and Monson (2010), cross-border migrants who reside within the Alexandra Township in Johannesburg live in poorer accommodation compared to that of South Africans. They are less likely to have electricity, running water and basic housing infrastructure than the South African residents of the township. Only one percent of the cross-border migrants had accessed low-cost housing provisioned by the Government (Misago et al., 2010). The current banking law consents to asylum-seekers, refugees and business-permit holders to opening bank accounts, provided that the correct documentation is brought forward. However, in practice, banks mostly decline access to underprivileged foreigners (Landau and Segatti, 2009, p23). It is evident from the research reviewed that cross-border migrants demonstrate generally low levels of security, safety and access to services.

This situation is not unique to South Africa. According to researchers Bollini and Siem (1995), migrants are far worse off than the average individuals in Canada. Many migrants face difficulties with finding housing and consequently commonly live in informal townships or settlements. Seasonal workers have been identified in several studies to be living in unsanitary conditions (Scott, 2004). Migrants with precarious status (MPS) are often found in employment deemed indecent and shunned by citizens of the host countries, where there is a high risk of them being exposed to diseases, fatal injuries and with little or no security of any provision for health in case of any adverse circumstances. Furthermore, most of the migrants work in the underground economy, where they are exploited (Brush and Vasuouram, 2006).

2.7.1 Challenges faced by undocumented migrants

While the challenge of undocumented persons is experienced on a smaller scale in African countries, particularly South Africa, similar problems are experienced by MPS. A case in point is in terms of access to health services as the MPS exist outside the systems which

manage health and basic-service provision (International Organization for Migration (IOM), 2013). Computerized systems which use digital information systems, such as biometric systems, are mainly used in social-service provision in developed countries. A similar system is currently being rolled out in South Africa, in particular in the Western Cape where the system requires a South African identification number. This reduces undocumented migrants' access to health.

The report from the Gallup annual world poll, which since 2005 has been conducted for about 150 countries globally, between 2009 and 2011, provides unique insights into the living and working conditions and perceptions of migrants' well-being. Evidence from the poll was gathered using indicators such as income, unemployment, and underemployment, happiness, satisfaction with health and feelings of security. Migrants generally scored low on all these measures of wellbeing, with the scores being lower for undocumented rather than documented migrants (IOM, 2013).

Undocumented migration has been identified as a global phenomenon impacting all countries through a diverse number of challenges and opportunities (Lori and Boyle, 2015). In a research article by Lori and Boyle (2015) examining migration in African countries, they found that while the push and pull factors differ from country to country, principal challenges for the destination countries have to do with the health sector which, in underdeveloped countries in particular, is generally under-capacitated (Lori and Boyle, 2015). The key challenges to migrants' access to health in South Africa includes (but is not limited to) being treated badly by a nurse, language barriers, being denied treatment due to a lack of documentation or recognition of documentation, being denied treatment as a result of foreign status, inappropriate treatment by administrative personnel at the health facilities and the fact that some migrants experience cost barriers (CoRMSA, 2009).

Findings of a study, involving 11 European Countries, investigating immigrants' access to health and basic services, housing, electricity, sanitary living conditions, and banking services were that they were difficult to access by immigrants (Commission of the European Communities, 2008). From this it became evident that migrants often face challenges in service access and in some cases end up having to pay high service fees legally or illegally (Commission of the European Communities, 2008). The key findings of the report brought to light the fact that access to healthcare, among other vital services, is a remarkable challenge and costly as undocumented immigrants experience discrimination and high service fees.

According to the World Health Organisation (WHO) commission (2008) on social determinants of health, factors such as unreliable income, inadequate housing, insecure working conditions, and a lack of access to healthcare are among the social determinants of poor health.

2.8 Social well-being

In 2010, an Integrated Biological and Behavioural Surveillance Survey (IBBSS) was conducted on farms by the IOM. According to the organization's findings, approximately 90% of migrants that were surveyed reported having received support from either friends or family (IOM, 2010). Furthermore, over 86% of the respondents stated that the work they did granted them the respect they received in the community (IOM, 2010). Over 75 % expressed that the farm-workers' community was one where individuals supported each other (IOM, 2010, p19). Hence it seems that, overall, there were positive attitudes regarding the social cohesion on the farms. This can be seen as a large contrast with research that has reported negative, discriminative and xenophobic attitudes towards immigrants.

This ambiguity demonstrates that migrants' wellbeing is highly reliant on the type of work they do and the place they reside (IOM, 2010, p20). Peberdy (2005, p12) notes that some migrants are isolated "by the nature of their job," and gave the example of domestic workers, who interact with a limited number of people. A study of migrants residing in Johannesburg established that cross-border migrants were likely to report that they did not feel part of the neighbourhood where they lived due to experiencing social exclusion from the community (Vearey et al., 2009).

Gindrey (2010, p7), conducted a study in Johannesburg, where 63% of Mozambicans, 95% of Somalis and 89% of Congolese reported to not having any South African friends. To a certain extent, the tendency of remaining in the same circle of one's nationality may be due to the preferences of migrants (IOM, 2010). For example, 51% of Congolese, 67% of Somalis and 54% of Mozambicans still found value in marrying someone of their own culture and nationality (IOM, 2012, p15).

The anti-foreigner sentiments in the South African population may be the greatest contributing factor beyond language and cultural similarities that cause migrants to remain

confined to the communities of their origin. From the same survey, 33% of South African respondents reported that they felt that immigrants were also contributing to the rise of criminality in Johannesburg (IOM, 2010). Only 38% of Congolese, 11% of Somali and 4% of Mozambicans reported trusting South Africans. By contrast, 21% of South Africans said they trusted foreigners (IOM, 2010, p21). According to the Afrobarometer survey, it was found that there has been an increase in distrust of foreigners in South Africa between the period of 2008-2012; 67% of South Africans reported a general distrust of foreigners, compared to a 60 % level of mistrust that had been reported in 2008 (IDASA, 2012).

According to a research study conducted in Canada, it has been stated that many of Canada's immigrants face several challenges regarding language, culture and experiences of racism in diverse forms. Vulnerability, however, remains the chief problematic aspect undermining the welfare of migrants in the destination countries, and particularly in the one reported by the research study (Bollini and Siem, 1995). Oxman-Martines, Lacroix and Hanley (2005) highlighted that immigrants are mostly likely to suffer from permanent fear of being denounced; stress and anxiety, isolation and a lack of control are part of everyday life for MPS. In Canada, the lack of medical coverage for migrants is viewed as the major barrier for accessing health care (Bollini and Siem, 1995).

Literature suggests that many refugees and migrants have been denied access to emergency and basic care due to the unwillingness of health professionals, which it has been argued is a result of xenophobic attitudes (Bollini and Siem, 1995). This has also resulted in migrants being charged inappropriate fees for the services that they had received. A number of foreigners have been reported to have been subjected to ill-treatment such as being made to wait longer periods in lines, in addition to other forms of discrimination (Bollini and Siem, 1995).

According to Nkosi (2004) and Pursell (2005), non-nationals have further reported to having not been granted the full course of prescribed medication needed to cure their sickness, due to their nationality. These barriers, which negatively impact the welfare of migrants, are encountered regardless of the migrants' documentation status. The literature reflects that the barriers seem to be embedded in the attitudes of local residents in destination countries to foreign nationals, particularly in South Africa, and not in the institutions providing the services. However, these barriers become relevant as the locals who have these perceptions are the ones employed in these institutions. Therefore, at the operational level, in spite of the

existence of non-discriminatory policies, these attitudes constrain migrants' access to these critical services.

2.9 Social services delivery challenges faced by immigrants

According to the literature, many immigrants who are legally in South Africa have had several experiences of being unable to access critical social services. Stone and Winterstein (2003) argue that this has been the result of discrimination, ignorance and inadequate documentation. For example, Section 5(1) of the South African Schools Act 84 of 1991 states that "a public school must admit learners and serve their educational requirements without unfairly discriminating in any way" (Stone and Winterstein, 2003, p24). Furthermore, Article 27 of the Refugees Act (130 of 1998) declares that refugees as well as their children are entitled to the same basic health services and basic primary education which the population of the republic receive as social benefits (cited in Stone and Winterstein, 2003). However, regardless of this official provision, asylum seekers and refugees still encounter several challenges in accessing educational services. The Department of Education (Belvedere, 2003) argues that the requirement for migrants to pay school fees is a barrier to education.

A study that was conducted in 2000 on the Somali refugee community in Johannesburg discovered that 70% of the children of Somalian refugees of school-going age were not enrolled in school (Peberdy and Majodina, 2000). Those children enrolled in schools noted that they had been subjected to xenophobic comments from teachers or fellow pupils (Peberdy and Majodina, 2000). According to a national study conducted in South Africa, 17% of asylum seekers and refugees reported they had not been granted emergency medical care due to not having the correct paperwork (Belvedere, 2003). Only 1% of refugees have ever lodged a complaint about being refused health services. According to the study, 24% of the respondents reported that they had not lodged any complaint, not because they did not want to, but because they were unsure where to report the complaint. As a result, there seems to be deep-seated negative perceptions of the institutions designed to deliver basic services and public goods to refugees and asylum seekers, which deters them from accessing social services through such outlets (Belvedere, 2003).

2.10 Migrants wellbeing and HIV

Much of the research that has been conducted pertaining to African immigrants in South Africa has been focused on the HIV/AIDS pandemic, and much focus has been placed on their general access to healthcare services as a whole. The SADC region has been recognised as the heartland of the HIV epidemic. In 2009, in South Africa alone, the HIV prevalence amongst adults (ages 15-49) was approximately 17.8% (IOM, 2010). It is estimated that in 2005, 63 million adults and children were living with HIV (IOM, 2010). Even before the HIV epidemic, the relation between communicable diseases and migration had been documented in the history of Southern Africa. Crush, Williams, Gouws and Lurie (2002) states that it was well known that the migrant labour system throughout the 20th century has been the core contributing factor to the spread of infectious diseases such as TB, and sexually-transmitted illnesses (STIs) like syphilis. They argue that as such it was no surprise that, at the end of apartheid when there was an increase in migration that this movement of people contributed immensely to the transmission of HIV.

Coffee, Lurie and Garnett (2007) argue that the relations between mobility, sexual behaviour, HIV and sexually transmitted infections (STI) transmissions is dynamic, and migrants should not be considered as the main carries of HIV. Migration increases vulnerability, but “it is the conditions associated with the migration process” or the “social disruption which characterizes certain types of migration” that affect vulnerability of individuals, rather than being a migrant per se (IOM, 2010; Decosas et al., as quoted by Singh, 2007, p14). Migration influences the spread of HIV purely by increasing the prevalence of high-risk associated with sexual behaviours.

A study conducted in France contradicts Coffee et al., (2007) argument that migrants should not be considered as the main carries of HIV. The study found that HIV rates amongst migrants were 2.56 per 1000 in 2003 as opposed to 0.82 per 1000 of the French population. Migrants that originated from Haiti and sub-Saharan Africa had the highest rates of infection, of 31.18 and 10.32 per 1000 population respectively (Ministere de la Sante, 2003). Of new infected cases in 2003, 32% were from sub-Saharan Africa. According to these findings, migrants are considered to be playing a great part in the rise of heterosexual transmission of HIV.

Nonetheless, the entitlement to medical treatment of HIV-positive refugees is commonly trespassed as an outcome of xenophobic attitudes levelled by health professionals against foreign nationals, thereby inhibiting migrants' ARV treatment (WHO, 2010). According to the Southern African Migration Programme (SAMP), medical xenophobia occurs when health professionals demonstrate ill-treatment towards patients as a result of their foreign identity, by withholding treatment or exhibiting any type of discrimination encouraged by enmity towards foreigners (Crush and Tawodzera, 2011, p12).

In 2011, a study investigating the existence of medical xenophobia in the South African public health system found that medical xenophobia is manifest in the following:

- Patients are required to show identification documentation and proof of residence status prior to treatment, with those lacking documentation being denied treatment;
- Health professionals refuse to communicate with patients in a common language or allow the use of translators;
- Treatment is sometimes accompanied with xenophobic statements, insults and other verbal abuse;
- Non-South African patients are required to wait until all South African patients have received medical attention, even if they have been waiting longer for treatment; and,
- Refugees and asylum seekers have such difficulty accessing ARV for HIV in public hospitals that many are forced to rely on NGO treatment programs (Crush and Tawodzera, 2011, p13).

2.10.1 Research studies on the prevalence of HIV among migrants

In 2009 and 2010, the IOM conducted two studies that surveyed 28 and 23 farms in the Mpumalanga and Limpopo provinces. The surveys included 1500 and 2810 farm workers (IOM, 2010). It was found that the HIV prevalence was very high for both migrants from Zimbabwe and non-migrants. At 39.5 %, the rate was double the prevalence among 15 to 49-year-old adult non-farm workers in the same provinces; 52.2 % of 30 to 34-year-old seasonal farm employees were also infected (IOM, 2010).

Extending the studies on migrants' health and HIV, the IOM (2010) collected data that illustrates the high level of HIV prevalence amongst both migrants from Zimbabwe and non-migrants working in the mining sector of South Africa. IOM (2010) found that 20% of coal miners and 30 % of gold miners were HIV positive, indicating prevalence rates 17% higher than those of the general population. It is evident that the current data indicates that the HIV prevalence among cross-border migrants is high. However, this does not mean that assumptions should be made that it will always be higher than that of non-migrants (IOM, 2010).

2.10.2 Women's higher vulnerability to HIV infection than men's

Research studies suggest that female farmworkers are more likely to be HIV infected than male farmworkers (Camlin, Hosegood, Newell, McGrath, Barnighausen and Snow, 2010). The IOM study found HIV prevalence amongst women farmworkers of 46.7 % in 2010, and 32.5% in 2009. This was compared with the 20.9 % and 30.9 % HIV prevalence in male farmworkers in the same years (IOM, 2010). The difference between South African women and cross-border migrants was not considerable: 40.8% for South Africans, 51.8% for Swazis and 41.5% for Mozambicans in the 2010 survey. Some studies found that poor financial situations for women contributed greatly to the high rates of HIV prevalence among them, irrespective of status (either as migrant or local). Munyewende, Rispel, Harris and Chersich (2011) argue that sexual-related decisions and behaviours adopted by these women have been shaped by their socioeconomic contexts. He further states that the low-income status and the associated income insecurities these women face result in them adopting survival strategies which, while beneficial in the short to medium term, have high cost and adverse implications for health welfare in the long term.

According to Singh (2007), many women employed transactional sex as a coping strategy; this was particularly the case if these women were breadwinners. What has been further noticed is that migrant women experience marginalization from their social networks. As a result of this their support structures fade over time, which raises their probability of partaking in transactional sex to attain either transport, accommodation or food (Singh 2010; IOM, 2010; Munyewende et al., 2011).

2.10.3 Tuberculosis in migrant populations

For many industrialized countries with a low prevalence of TB, the re-emergence of TB has been identified as a major problem. TB has been linked with ethnic minorities, the homeless and migrants (Porter and McAdam, 1994). In destination countries globally, migrants have been identified as being more vulnerable in cases of epidemics or where high levels of communicable diseases are experienced.

Furthermore, they still face challenges in accessing health care due to social discrimination, social marginalization and poverty. Roura, Dominga, Leyva-Moral and Pool (2015) conducted a systematic review of qualitative literature of TB in migrant populations. The purpose of the review which was based on at least 30 articles on TB was to investigate the perceptions concerning TB among immigrant populations so as to design effective TB-control programmes. The qualitative articles which were reviewed were research studies conducted in the US, New Zealand, the United Kingdom, Canada, China, Kazakhstan, Nepal, Norway, Oman, Spain, Sweden and Switzerland (Roura et al., 2015).

Growing evidence supports the understanding that migrants' characteristics of social and economic inequality endure migrants' higher risk to TB, as do discriminatory strategies found in non-health sectors such as immigration, labour and social protection (IOM, 2013, p18). The existing gap of TB prevention and control approaches for migrant populations globally creates significant constraints in reaching TB eradication targets in numerous origin, transit and destination countries for migrants (IOM, 2013). This is due to myriad country-specific conditions, from low public funds to incapacitated health institutions which prioritise locals against foreign nationals.

It must be noted that TB is highly prevalent among migrants as a result of predisposing-risk factors. Migrants face higher exposure to TB infection as a result of their congested living and working conditions, and being placed at a higher risk of being HIV infected, malnutrition and substance abuse which is primarily induced by alienation and social exclusion (IOM, 2013). Furthermore, delays encountered in TB diagnosis amongst migrants are often related with difficulty in accessing healthcare services. Delays in accessing health care are associated with a lack of education associated with poor access to health information, poor health-seeking behaviours, cultural beliefs, stigma (symptomatic of the belief that migrants bring

diseases to destination countries) and marginalization (IOM, 2013). These are discussed in more detail below.

Social barriers, in particular language and cultural barriers play a critical role in inhibiting migrants' access to TB-control-related information on prevention, transmission and latent infections (IOM, 2013, p12). Stigma-related fear is an important social barrier especially in countries where violent behaviour towards migrants is a frequent occurrence, as in South Africa. In addition, lack of awareness among migrants of their right to health services, low health-related spending capacity and inhospitable health services act as effective social barriers to accessing healthcare provision and the early treatment of communicable diseases such as TB (IOM, 2013).

Finally, economic costs are salient barriers to accessing health care. The enormous distress of TB-related morbidity and mortality amongst migrants has extensive multi-layered negative economic effects. These are experienced at household and social level through the loss of productivity and earnings in the subdivisions that employ them. Furthermore, financial constraints on health systems are experienced at a national level in both source and destination countries (IOM, 2013).

2.10.4 Knowledge of attitudes towards and beliefs about TB

From the research it is apparent that there exists a low level of knowledge about TB amongst migrants worldwide, including misconceptions on how TB is transmitted, although some respondents demonstrate a basic understanding of bacteria and infections regarding air-borne transmissions (Johnson, 2006). Across all studies, respondents have demonstrated an unclear understanding of the transmission mechanism of TB, with a variety of explanations regarding the disease, its transmission, and causative factors evident. Respondents demonstrated knowledge that TB is highly contagious and feared contracting it (Gibson, Cave, Doering, Ortizz and Harms, 2005). Respondents viewed TB as a disease of the lungs, with symptoms of coughing and coughing up blood (Johnson, 2006, p13). One of the respondents selected from the studies' survey stated that most people confused TB with lung cancer or asthma. Respondents understood that vaccination was important but the difference between BCG and TB treatment was unclear (Brewin, Jones, Kelly, McDonald and Beasley, 2006). The participants acknowledged that a weak social network, illiteracy, temporary residence for illegal refugees and police extortion were factors hindering their access to health care.

2.10.5 Seeking healthcare and TB diagnosis

According to Huffman, Veen, Hennink and McFarland (2012), migrants have been encouraged to seek health care in the hope of receiving negative results of TB testing, to elude stigma related with it, to earn the right to stay lawfully in the country until the completion of treatment and the need to know their health status. The process of TB diagnosis is influenced by myriad barriers to accessing health care, including a lack of knowledge of current, free TB diagnosis and screening services at designated centres; illiteracy and language barriers (Kirwan, Nicholson, Baral and Newell, 2009); fear of painful tests (Wieland, Weis, Yawn, Sullivan and Millington, 2012); transport difficulties, queues and waiting in long lines; not having health insurance (Huffman, Veen, Hennink and McFarland, 2012); the presence of clinics for migrants in dangerous neighbourhoods (Ito, 1999), and social exclusion if results are found to be positive. Ng Shui, Park and Kearns (2008) argue that over time immigrant's play down the importance of any symptoms, self-diagnose and self-medicate. This has led to immigrants making use of pharmacies, private clinics as well as public healthcare centres (Ng Shiu, Park and Kearns, 2008). The absence of any symptoms has led many immigrants to not go for any screening or prevention of TB.

2.10.6 TB treatment

Many immigrants still experience obstacles in accessing treatment when seeking healthcare services. Migrating to another country comes with the difficulty of not understanding a new language (Ito, 1999) which disadvantages immigrants as they remain uninformed about any freely-available treatment. Often, the opening hours of clinics do not correspond with those of the patients' working hours (Kirwan et al., 2009). Furthermore, the use of interpreters for TB treatment has been found to be problematic as patients hold back from sharing sensitive information, due to the fear of a loss of privacy and stigmatization (Kulane, Ahlberg and Berggeren, 2010).

In addition patients, who, as a result of the treatment, experience a decrease or disappearance of the symptoms of TB, tend to stop their treatment prematurely believing they are now well. Patients have been found to question the need to continue with the treatment and further gave incorrect information of adherence (McEwen and Boyle, 2007). According to a study located in the US, the clinic director and migrant-community leader were very concerned about the TB patients' non adherence to the TB treatment (McEwen and Boyle, 2007).

2.10.7 The social repercussions of TB

In most of the studies, immigrants who had been infected with TB had been victims of stigmatization. For many this stemmed from being labelled as an ‘at risk group’, as health professionals treated immigrant patients in a different manner (Bender, Andrewa and Peter, 2010, p27). Within communities, being infected with TB was seen as shameful, dirty, sinful and associated with immoral behaviour. An outcome of this was that immigrants would frequently hide being diagnosed with TB (Wei, Chen, Chen, Newell and Li, 2009).

2.11 Immigrants’ awareness and knowledge about available healthcare services.

Research conducted in Canada which examined access to health care among undocumented migrants and refugees found that these categories of immigrants are uninsured and have limited access to medical facilities (Rousseau et al., 2008). The research also established that healthcare access is difficult to obtain for these categories of immigrants, this difficulty being further entrenched by these immigrants’ limited awareness of healthcare information, through ignorance, neglect, reliance on secondary information, and fear associated with lack of documentation in the case of MPS.

A study in the US reveals that a lack of medical insurance, with lower quality and quantity of medical care use, increases morbidity among adults and children. This, coupled with a lack of awareness, raises the risk profile in case of medical conditions and emergencies (Rousseau et al., 2008). Lack of necessary documentation results in immigrants having to pay high off-desk fees to get medical assistance. Such high fees discourage their health-seeking behaviour, and reduce their awareness of available health services and facilities. This is especially the case with chronic communicable illnesses.

Off-balance medical access refers to a situation where patients obtain medical care through officials in off-balance payments which do not include proper documentation and extensive consulting (Rousseau et al., 2008). As a result, the complete scope of healthcare services and facilities that may be available, or even better technology involving advanced procedures, remain unknown and inaccessible to immigrants. One fundamental limitation in the literature concerns the limited information about immigrants’ awareness of the availability of healthcare facilities and services, and protocols applicable to them.

2.12 Barriers to accessing healthcare services

The key challenges to migrants' access to health in South Africa includes but is not limited to: being treated badly by a nurse; language barriers; being denied treatment due to a lack of documentation or recognition of documentation; being denied treatment as a result of foreign status; inappropriate treatment by administrative personnel at the health facilities; potential cost barriers, and also stigma attached to the myth – particularly prevalent in South Africa – that immigrants are responsible for the spread of communicable diseases (CoRMSA, 2009).

2.12.1 Xenophobic attitudes

In order to ensure that refugees receive the required protection, the perceptions and assumptions that stigmatise refugees from other African countries in South Africa need to be addressed. According to the HSRC (2008), refugees now receive temporary protection unlike during the apartheid era when refugees were not welcomed into the country. However, refugees are expected to go back to their home country once conditions there have improved.

A survey conducted by SAMP found that 87% of South Africans felt that too many foreigners were being let into the country (HSRC, 2008). The manifestation of xenophobia in South Africa has been influenced by various factors. Amongst these are the exploitation of refugees in employment and housing matters, social exclusion of refugees in their communities, and violent attacks that have been levelled against refugees.

2.12.1.1 Attitudes of healthcare professionals

According to Moyo (2010), the shortage of staff, resources and materials have also contributed to the ill treatment that most immigrants encounter when requesting healthcare services. As a result, there is this notion that locals should be given first preference when it comes to the accessing of health care. This has resulted in immigrants facing significant discrimination. A number of health professionals in Johannesburg clinics indicated that it was 'okay' to mistreat African immigrants when it came to providing them health care; furthermore, it has also been reported that many receptionists at help desks take it upon themselves to decide whether an immigrant deserves to be given health care or not (Moyo, 2010).

According to Nkosi (2004), the inability of many health professionals to distinguish between the different types of migrants (by classifying them into one group) has resulted in refugees not being granted access to basic and emergency health services. Nkosi's article gives evidence of discriminatory attitudes in the health service, providing as an example that while waiting to be served, a refugee reportedly overheard a nurse talking to one of her colleagues about how foreigners were taking the government's money and using the country's resources. The nurse was further heard to complain about the fact that foreigners who were doing this were having too many babies (Nkosi, 2004).

2.12.2 Language

Speaking South African languages has been identified as one of the factors that is a challenge for immigrants. Language difficulties pose a challenge for both the immigrants and the health professionals. Language is recognised as a marker of belonging. It clearly separates those who do belong from those who do not belong. (Crush and Tawodzera, 2011)

Regardless of legislation enforcing the provision of health care to immigrants, and irrespective of the existence of correct or incorrect documentation, this is still a major issue when many immigrants are requesting healthcare services (Vearey, 2008). According to Moyo (2010), many undocumented immigrants have resorted to getting false paper work as a way of accessing healthcare services. There are a number of challenges that have thereafter taken place when immigrants have resorted to such measures. Many healthcare providers have said they felt as if immigrants were cheating the system by doing this. Furthermore, language has served as a barrier when it comes to accessing health care for migrants. The section below makes use of caesarean births amongst migrants as an example of how language has been found to be a barrier.

Merry, Small, Blondel and Gagnon (2013) conducted a systematic review with the aim of finding out if international women migrants in Western, industrialised countries have different rates of caesarean births than do women citizens in the receiving country. The study makes use of 76 studies that met the inclusion criteria. These included studies from Latin America, the Caribbean, South Asia, Europe, Canada and Israel (Merry et al., 2013). The findings were that there was a 69% difference in caesarean rates between migrants and non-migrants (Merry et al., 2013). It further identified that migrant women from sub-Saharan Africa, Somalia and Southern Asia have a higher use of caesareans compared to the women

born in the receiving country. By contrast, Vietnamese and Eastern European women had lower caesarean rates. The main reasons that migrants had higher risks of caesarean deliveries were: the language/communication barrier (being unable to speak the common language), lower socio-economic status, being seen as having poor maternal health, gestational diabetes, feto-pelvic disproportion and the lack of prenatal care (Merry et al., 2013,p18).

2.12.3 Stigma and marginalization

The vulnerability of immigrants has been greatly influenced by issues relating to stigma and marginalization. According to Landau (2007, p10), “the distinction in appearance (traditional attire), cultural and religious practices, language barriers, speaking with an accent (even among immigrants who speak English), and skin tone” were factors noted as contributing to stigma. The stigmatization of immigrants can be aggravated by community alarms pertaining to the effects of immigration on community assets (Landau, 2007). It has become a general assumption amongst many communities in South Africa that immigrants – particularly illegal immigrants – overburden already limited resources. According to Landau (2007), research has suggested that immigrants overall, especially those who are undocumented, use comparatively few healthcare services.

Research has further suggested that a proportion of immigrants have become reluctant to make use of healthcare services. This is related to having received poor treatment. If health professionals do not have the desire to serve immigrants, the longer delays and frustration affects both patients and healthcare professionals. Migrants, particularly those who have limited English proficiency, are usually less satisfied than non-migrants with the healthcare services that they receive (Crush and Williams, 2001). In a study conducted on immigrants in the USA, it was found that reports of discriminative acts against patients in healthcare settings came predominantly from migrants as opposed to non-migrants (Monga, Veller and Venters, 2014). These perceptions of being discriminated against have strengthened the feelings of stigmatization and have led to the decline in the use of healthcare services for many immigrants in the USA.

2.13 Conclusion

Literature has shown that South Africa, as well as several Southern-African countries, has agreed to international, constitutional and sub-regional (Southern African countries) policies that tie them to assisting refugees. The provision of health care is a factor that is common amongst these policies. Literature has further shown that political conflicts in countries such as the DRC have been the cause of refugees moving into South Africa, the USA, and other countries. Literature from the USA on refugees found that their health status was one affected by TB, hypertension, HIV/AIDS, ophthalmological and heart disease. This corresponds with literature from South Africa that highlights that international migrants in its country suffer from HIV/AIDS as well as TB. Studies from Canada point out that TB is highly prevalent among migrants. These conditions are generally a result of risk factors experienced by migrants, since migrants face higher exposure to TB infection as a consequence of their congested living and working environments, higher exposure to HIV infections, malnutrition and substance abuse which is primarily induced by marginalization and social exclusion.

Canadian literature suggests that MPS are impacted adversely by the living and health conditions of the new legal systems they find in the destination countries, including education, housing and health care (WHO, 2004). South African literature points out that migrants are subjected to living in overcrowded conditions. Studies conducted in South Africa have shown that immigrants have several challenges regarding social delivery. Stone and Winterstein (2003) argue that this has been the result of discrimination, ignorance and inadequate documentation. Furthermore, literature highlights that refugee's lack medical insurance in both Canada and the USA. This has contributed to morbidity amongst children and adults. Due to this social exclusion it becomes difficult for migrants to be aware of healthcare services and any additional information concerning these services.

Literature has further shown that language remains a barrier for immigrants when accessing healthcare. This is evident even with the birth experiences of many international migrants. Studies have shown that the language barrier has contributed to the higher use of caesareans amongst migrants. Health professionals have also been found to be unaccommodating of international migrants when they seek health care. Landau (2007,p10) states that “ the distinction in appearance, for example, wearing traditional dress, cultural and religious practices, language barriers, speaking with an accent (even among immigrants who speak English), and skin tone”, were factors noted as contributing to stigma and marginalisation.

This situation is not only unique in South Africa, but is described also in studies based in the USA.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter provides the outline of the study design and the relevant research used for the study to be carried out. The study was designed in a manner to explore the experiences of French-speaking African-immigrant car guards with regards to the use of healthcare services in Durban, South Africa. This chapter is structured to focus on the study area and sampling procedures, before concluding with a discussion of the ethical issues and limitations of this study.

3.2 Study area and the population of the study

The study was conducted at the Queensmead Spar, Davenport Square and Pick 'n Pay Hypermarket. The Queensmead Spar is situated in the Durban area known as Umbilo. The Davenport Square is located in Glenwood, better known as the Berea area in Durban. Lastly, the Pick 'n Pay Hypermarket that was used in this study is located in the Durban North area. These shopping malls were chosen firstly because of their proximity and easy accessibility for the researcher. Secondly, the malls had the required respondents – African-immigrant car guards – for the study.

Twenty car guards, of whom all are immigrants, work at the Davenport mall. Queensmead Spar and Pick 'n Pay Hypermarket each have a total of 18 car guards. Amongst these are a few car guards that are hired on a temporary basis. They are on standby in case one of the permanent car guards is unable to come to work on that day. The car guards work either the day shift which is from 8:00a.m.-4:00p.m., or the afternoon shift which is from 4:00p.m.-8:00p.m. During the working hours of their shifts, these car guards are required to be at their posts at all times. This means that there is no allowance for lunch time during their shift; they are required to eat before or after the shift.

As a prerequisite of the Private Security Industry Regulatory Authority (PSIRA), all of Durban's informal parking attendants/car guards are required to be registered with this organisation. The purpose of the PSIRA is to regulate the private security industry. Furthermore, it “exercises control over the practice of the occupation of security service

providers in the public and national interest, and the interest of the industry itself' (PSIRA, 2002, p12). Section 20 of the Private Security Industry Regulations Act (Act 56 of 2001) requires and stipulates that all those who render a "security service" must be registered with PSIRA. PSIRA has publicly noted, with reference to informal parking attendants, that "all car guards who render a security service must be registered with the Authority prior to the rendering of a security service" (PSIRA, 2002, p12). Each car guard is expected to pay a fee from R27 to R40 per day for the parking spot that they are working from. The difference in price range is purely determined by the different sections of the parking areas of the malls, as some are busier than others. This is applicable to all car guards at the three shopping centres. The money is collected daily by the supervisors, who then pass it on to the owners of the security companies.

The car guard industry is one that is highly male dominated. When supervisors were questioned about this they explained that women are commonly unwilling to do this type of work. The few women that have tried it on temporary basis have often not returned when they had been given the chance to be a car guard. When they were asked why this was the case, they explained that the job of being a car guard was too strenuous on one's body due to standing for long periods. Hence, these supervisors commented that males are more willing to do this type of job. The difference noted between the representivity of the genders is not identified by supervisors as being due to their preference, but more due to the unwillingness of females to do this type of job. One of the supervisors further stated that he could not even say it is an issue of the women not being able to meet certain requirements; it was just hardly the case that women approach them wanting this work, and those who have attempted doing it have often not continued.

The proportion of foreigners who work in the industry relative to South Africans was observed to be much greater. From the several conversations that took place with the supervisors it appears that the main reason for this is that the supervisors themselves are foreigners. As part of their duties they are expected to recruit car guards if there are vacant spaces available. With most foreigners staying in the same parts of town it is easier for supervisors to recruit individuals from their residential areas and country of origin. For example, the supervisors from these three malls are originally from the DRC. As a result of this the majority of the car guards in these malls are from the DRC. Hence, there is a much higher prevalence of foreign than South African car guards.

The location of these shopping centres in middle-class urban areas has benefitted car guards working in these areas. These areas are considered middle class as the individuals who reside in them fit Schlemmer's characterisation of middle class as having middle-income-bracket earnings, investment in cultural capital (education) and fixed capital (property) that give them independence and sustainability (Schlemmer, 2005). Individuals who reside in these areas commonly have similar occupations or occupations that have nearly the same salary. The major occupations are industrial, administrative and professional in nature (StatsSA, 2000). These areas are known for having good security, shopping malls at close proximity to them, and high density in the population.

Many of the car guards that were interviewed highlighted that the income from being a car guard was not that good. However, the money that a guard would make from working in these malls is much better than that earned when working, for example, at the beachfront. Firstly, this is because malls have peak hours during the morning and afternoon when the guards know that they are bound to make money every day, unlike areas such as the beachfront which are normally busy only on the weekend.

Secondly, the ticketing system currently works to the guards' advantage. These shopping centres do not yet have an automated system of issuing a ticket when customers enter the parking area, and charging for parking using the ticket to determine the duration of the parking before exiting. This means that shoppers still rely on the car guards to oversee their cars while in the shopping malls. Hence, the shoppers are still inclined to tip the car guards without having to pay a parking-ticket fee as well. Several car guards noted that some of their friends who work at malls where the parking-ticket fee system is in effect noticed a decline in the tips that they would normally receive from shoppers, once this system had been implemented. What was said was that regular shoppers in such malls would then want to reserve the money (that they would have normally tipped the guards) for the parking ticket fee.

3.3 Research methodology

3.3.1 Qualitative methods

According to Terre Blanche and Kelly (1999) qualitative researchers aspire to make sense of feelings, experiences, social structures and phenomenon as they occur in the real world. One advantage of this method is that it allows the researcher to study selected issues in depth (Blanche, Durrheim and Painter, 2006). The use of qualitative methods for this research seemed most relevant as the study seeks to explore the experiences of African immigrant car guards' access to healthcare services. It enabled the respondents to talk widely about their experiences and give meaning to them with regards to healthcare services. As a result of this method, the researcher was able to gather detailed information on the personal experiences, perceptions, hindering factors and awareness of the healthcare services available to the car guards.

Semi-structured in-depth interviews, a characteristic of qualitative methods, were used for data collection as they facilitated a better understanding of individual experiences and perceptions. This enabled the respondents to speak about their experiences in their own words. Additionally, this method allows the researcher to probe and ask questions for clarity if required, and to follow up on potentially new avenues for exploration as they emerge in the interview process (Fox-Wolfgramm, 1997).

3.4 Data collection methods

3.4.1 Selection and recruitment of respondents

The fundamental consideration when it comes to purposive sampling is the selection of information-rich cases – individuals who are able to provide the best information to ensure that the objectives of the study are achieved (Kumar, 1999). The reason purposive sampling was employed was, firstly, because it is known to be useful when little research has been done on the study area, such as addressed by this study. Secondly, the identified population was perceived to possess the required characteristics that would provide sufficient information for the study objectives. Thirdly, it was appropriate because of the researcher's ease of access to the identified population.

Before undertaking the study, the researcher had preliminary meetings with the supervisors of the different malls in order to obtain the permission to conduct the study. These meetings also provided the opportunity to assess car guards that would be interested in participating in the study, and providing information on the accessibility of healthcare services for immigrants. In order to recruit respondents for the study, the researcher sought assistance from another researcher who was more familiar with the car guards in certain malls. This researcher lived in the residential area of Umbilo and was a frequent patron of the Queensmead Spar and Davenport Square shopping centers. Over the years the researcher, as a daily user of these shopping centers, has formed relationships with a number of car guards. She was helpful in that she introduced respondents who were willing to participate in the study to the study researcher. Furthermore, as well as performing introductions, she assisted in explaining the nature of the study and its relevance to the respondents. After these introductions, good rapport was established with the respondents. Each respondent was informed well in advance about the objectives of the study and consented to being part of the research. Some respondents were able to suggest other respondents who were willing to be part of the study.

Establishing good rapport with the car guards' supervisors of these three malls was beneficial for the study. In addition to the assistance of the female researcher, these supervisors were able to refer the researcher of the study to car guards who they knew would be willing to participate in the study. These supervisors could be regarded as what is referred to in qualitative research as 'gate keepers'. These are individuals that a society or a group of individuals are most familiar with (Shenton and Hyter, 2004), respect and look up to. Hence they have a great influence on the way of thinking and decision making of these societies and groups.

During the morning meeting with which this phase of the research commenced at all three shopping malls, the supervisors introduced the researcher to the group of car guards and further explained the purpose of the study. They encouraged the car guards to participate in the study. This approach was beneficial as the car guards were being encouraged by their own superiors in whom they had confidence. It made it easier for the researcher to form good rapport with the respondents. This approach worked most effectively at the Pick 'n Pay Hypermarket. Several car guards volunteered to be interviewed even before the researcher was given the platform to further elaborate on the study.

3.4.2 In-depth interviews

In total, 16 interviews were conducted and completed. Out of the 16 interviews, 4 were conducted at Queensmead Spar, 6 at the Davenport Square and 6 at Pick 'n Pay Hypermarket. Only two of the respondents were females. The interviews took place over a period of four months from March to June 2014. The study targeted individuals who were French-speaking African-immigrant car guards who worked at one of the three malls. These three malls were easily accessible for the researcher, using public transport. This meant that there was a large pool of car guards for selection, and the number of respondents was not constrained by difficult access. The car guards were French-speaking Africans who have, over the years, learned to speak English. This facilitated good communication between the researcher and the respondents. The study targeted individuals who were over the age of 18 years. This was very easy to achieve as most car guards were over the age of 25. This meant that the responses that were provided by the respondents were mature, and ensured rich data to work with.

A semi-structured interview schedule was used for the study (Terre Blanche and Kelly, 1999), as it would not limit the respondents only to the questions raised in the interview guide. It allowed for respondents to share relevant information that the researcher might have not thought of until conducting the interview. According to Rosenthal and Rosnow (1991), this interaction between the researcher and respondent forms a sense of trust between the two parties. This was extremely important as being an immigrant in a foreign country is associated mostly with being isolated by permanent citizens of that country. It required that the researcher build a level of trust in order for respondents to communicate honestly and freely.

Furthermore, the semi-structured interview schedule included open-ended questions that were constructed with the help of the literature. The open-ended questions were designed in a manner that helped understand the personal experiences of African-immigrant car guards when accessing healthcare services, their perspectives, barriers and awareness of the healthcare services available to them. The choice of using interviews as a tool provides the researcher the chance to gain insight into some of the challenges immigrants face with it comes to accessing healthcare services in Durban. The use of in-depth interviews makes it possible to explore a topic in depth. The interview guide (see Appendix 1) covered five main questions: the personal experiences of African-immigrant car guards seeking healthcare

services, perceptions of the healthcare services, the hindering factors that cause immigrants to end up not using healthcare services, the awareness of healthcare services available to immigrants and recommendations on how to improve the accessibility of healthcare services for African immigrant car guards. A set of probes were set for each question that made it possible to produce in-depth information.

In addition to this, certain changes were made to the interview schedule. In the first section of the interview guide (which records socio-demographic characteristics) an additional question was added. It asked, “Do you ever long to go back home?” This was asked out of interest to find out, after reasons for coming to South Africa had been stated, whether or not participants had any intentions or desires of returning to their country of origin. There have been many conspiracies and assumptions made by South Africans regarding the duration of the foreigners’ stay in the country. By asking this question, more clarity would be provided on this matter.

After the first three interviews, it became apparent that respondents did not fully understand the term ‘healthcare services’. Respondents would either request the researcher to repeat the question a number of times, or have a confused facial expression while saying, “Healthcare services?” An additional question was added at the start of section two, which explored the personal experience of accessing health care services. It asked for a brief definition of what respondents understood by the term healthcare services. This was done in order to establish early within each interview whether or not the term was well understood. If not, an explanation of healthcare services was provided by the researcher, to ensure that the following questions were not affected by a lack of understanding of this term.

Question 6 of the same section was changed from the original question which was: What are the types of healthcare services that are available to you in South Africa? to: What are the types of healthcare services that are available to you in South Africa that you know of? A probe was also added after this question which asked: How have you come to know about them? If a respondent’s answer was ‘no’, this was followed by, “Why are you not aware of the healthcare services available? A follow up question which was added after question 6 asked: What are some of the healthcare services that you have used in South Africa? This question was later asked in both of the sections, five and six, that had separate questions for females and males. This was done with the intention of seeing if the respondents would have similar answers to the question that had been asked at the start of the interview. This on its

own revealed consistency and gave assurance that the respondents knew what they were answering.

In the males' section, the following questions were asked: 'Out of these services which one have you used? HIV/AIDS testing, circumcision, STI testing, TB testing, Blood and Urine analysis, Testosterone screening, full body check-up?' The question: 'What healthcare services do you use most commonly?' was also moved to the females' separate questions and was placed as the first question. These changes were made, firstly, to find out how well informed the respondents were of the healthcare services available to them, and secondly, to evaluate the consistency in the use of these healthcare services.

Lastly, two additional questions were added at the start of section 6. They applied to males who had children. The first question asked: 'Were you present during the period when your wife/partner was giving birth?' The second additional question asked: 'Are you aware if your wife/partner attended both prenatal and postnatal care?' The aim of these questions was to assess how aware males were about health matters relating to their partners. Furthermore, it was to evaluate whether or not any encouragement was given by male respondents to their partners to seeking these healthcare services.

3.4.3 Process of data collection

All interviews were conducted on the premises of the shopping centres. They were conducted within the working hours of the respondents. Each respondent specified the date and time that they felt would be most suitable for their interview to take place. Most respondents preferred that interviews commence during the early morning hours. The reason behind this was that the shopping centres were less busy during these times. Respondents felt that this would allow them to fully engage with the researcher and the questions being asked. As a result of this, all interviews were conducted between 7:30a.m. and 9:00a.m. Only two out of the 16 respondents requested that their interviews be conducted on a day that these respondents would not be working. The two respondents were not willing to compromise any of their work hours. As a result, they preferred that they be interviewed on a day when they were free and could fully focus on the interview at hand. Both of these interviews were still conducted within the shopping centre's grounds. The respondents felt it was the most convenient and comfortable place for their interviews to be conducted as they were accustomed to these

areas. From the researcher's observation there was no difference with the level of information given to these respondents compared with those who had scheduled their interviews for early in the morning. Overall, respondents were all willing to answer all the questions and in as much detail as possible, as they had fully committed themselves to being part of the research study.

As there were no offices specifically for the use by the car guards in these shopping centres, all interviews had to take place in very secluded areas of the malls. The top roof parking area was the venue commonly used throughout the interviews, predominantly at the Queensmead Spar and Davenport Square, as it ensured that privacy was obtained at all times. It further eliminated the issue of noise from passing pedestrians, hooting cars and noise from passing traffic, all of which would have affected the quality of the recordings. By using the rooftop parking areas the researcher was able to obtain good and clear-quality recordings of all the interviews. Furthermore, this area proved to be very convenient because interviews could be conducted regardless of the weather conditions. On the other hand, Pick 'n Pay Hypermarket has a large, flat basement parking space, the use of which enabled interviews to be conducted in parking areas that were further away from the commonly-used parking spaces nearest the shopping centre. Fortunately, throughout the data collection period, weather conditions were not of any disturbance, nor were they reason to reschedule appointments. However, interviews were conducted while standing or sitting on a flight of steps. Overall, no interviews were rescheduled as respondents remained faithful to the dates and time they had availed themselves of.

All interviews were conducted in English, and each was recorded with a digital recorder. In addition to this, notes were written during each interview. Prior to the start of each interview the respondents' consent was required before recording the interview. On average, interviews ranged between thirty and 45 minutes. The duration of each interview depended purely on the amount of information each respondent was willing to share. The commonly noted trend was that respondents who had been privileged enough to attend a tertiary institution had more information to share. Those respondents who were only able to attend lower grades at a High (Secondary) school level generally had less information to share.

A few interviews were interrupted by cars that were exiting the parking area. This meant that the recorder had to be placed on pause until passing cars had passed by. The researcher made sure to request permission to pause the recorder at these times, prior to this taking place.

Respondents were very understanding of this and in some cases they would be the ones notifying the researcher of the possibility of this occurring. The following table summarizes the demographic characteristics of each respondent in the study.

Table 2: Demographic characteristics of the respondents

No.	Gender	Age	Country of origin	Marital status	Level of education	Other sources of income
1	Female	33	Rwanda	Married	2 nd year in a Nursing degree	Husband delivery guy for KFC
2	Female	32	DRC	Married	Grade 12	Works at the salon part time
3	Male	41	Rwanda	Married	1 st year in Pharmacy	No other source
4	Male	39	Rwanda	Married	2 nd year in Accounting	Wife is also a car guard
5	Male	43	DRC	Married	Grade 9	Has a second job at night
6	Male	39	DRC	Married	Grade 9	Wife works at a salon
7	Male	34	DRC	Married	Grade 10	Wife works at the salon
8	Male	38	DRC	Divorced	1st year in business studies	No other source of income
9	Male	49	DRC	Married	Studied only 3 years of a medical degree	Wife has a small salon in Isipingo
10	Male	35	DRC	Divorced	Grade 12	No other source of income
11	Male	33	DRC	Separated with his wife	Grade 10	No other source of income
12	Male	24	DRC	Single	A degree in Psychology	No other source of income
13	Male	36	DRC	Single	Grade 10	No other source of income
14	Male	43	DRC	Married	Currently doing his Master's degree	Wife has a child day care centre.
15	Male	41	DRC	Married	Studied the first 3 years of a medicine degree	No other source of income
16	Male	43	DRC	Single	Grade 12	No other source of income

3.5 Data analysis methods

Interpretive analysis was used to analyse the data that was collected for this study. According to Jessup and Trauth (2000, p12), the intentions of this type of research is to “piece together people's words, observations, and documents into a coherent picture expressed through the voices of the participants”. Authors Terre Blanche and Kelly (1999) state that the interpretive research method takes on the notion that people’s personal experiences are real, that we come to understand others’ experiences by interacting with them, and that qualitative methods are most suitable for this objective. Interpretive analysis is associated with being an umbrella term for different analytic techniques such as phenomenology, grounded theory and thematic content analysis (Terre Blanche and Kelly, 1999). The data that was gathered from the interviews conducted in this study were analysed using the thematic content analysis.

The study made use of thematic analysis to identify and classify themes within the data collected. According to Terre Blanche and Kelly (1999), the thematic analysis technique can be seen as more inductive. This is because the categories in which the themes are arranged were not decided in advance of the data coding, but derived following the interviews. It must be noted that the categories were motivated by precise analysis but the nature of the categories and the themes investigated is not predetermined.

According to Sandelowski (1995), the data analysis process is an eclectic process. Creswell, Plano Clark, Gutmann and Handson (2003) further state that this process occurs simultaneously and iteratively with data collection, data interpretation and report writing. Authors Marshall and Rossman (1989) indicate that it is based on data reduction and interpretation. The data analysis process requires the researcher to read over the transcripts a number of times in order to grasp fully the main issues that have been raised in the interviews.

As soon as the transcribing of the interviews was completed, relevant passages were extracted from the text. This was followed by identifying the key themes and concepts and coding them to ensure a rich foundation to base the analysis on. This also made it possible to compare the findings and present rich data. Hereafter, all opinions, individual’s personal experiences and comments were arranged according to the recurring, designated themes for all the interview transcripts. The process of arranging the coded data into common themes enabled meaning to

be given to the experiences of African-immigrant car guards with regards to accessing healthcare services in Durban, South Africa.

The themes ranged from one sentence to paragraphs. The main themes were then integrated in order to convey the analysis. The themes that had been set were reread and deduced in a manner that they provide insight into the everyday experience of African-immigrant car guards with regards to accessing health care services. Once the coding, translating and arranging of data was done the outcomes were described. This included the final analysis of results, making an argument with regards to the research questions and referring to the theoretical framework. The main findings are discussed in chapter five.

3.6 Trustworthiness

The four strategies employed in this study to enhance the trustworthiness of the data include: credibility, dependability, transferability and conformability.

3.6.1 Credibility

Credibility deals with the focus of the research and how well the data and process of analysis addresses the focus of the study (Graneheim and Lundman, 2004). To ensure this, the researcher will select participants from various age groups, gender and context while making sure that the amount of data collected is sufficient to answer the research questions. The research project used credible qualitative research sampling techniques in identifying study participants. Purposive sampling techniques were utilised. The purpose of the selection of the sample was more about credibility as opposed to representivity.

3.6.2 Dependability

Dependability is a concept that is closely linked with reliability. However, dependability requires that the researcher thoroughly describes, and precisely follows, a clear and thoughtful research strategy (Marshall and Rossman, 2014). This was done by the researcher providing a clear explanation of how the data was collected, recorded, coded and then analysed. As a result of this all study materials, data, transcripts, notes, coded materials, interview notes and records have been kept available for record purposes. According to

Barbie and Mouton (2001), research materials can be kept and verified to attest that conclusions, findings and interpretations refer to what is supported by the data, and that there is coherence between data and the findings. The use of in-depth description of the methodology can facilitate a repeat of the study. It is in this manner as well, that conformability of the findings was met. Furthermore, each finding was also checked against literature.

3.6.3 Transferability

Transferability focuses on the extent to which the results of the study can be transferred to another context (Graneheim and Lundman, 2004) – was achieved by a detailed explanation of the study sample such as context, age group, background and how the participants were selected.

3.6.4 Confirmability

Confirmability refers to the steps that the researcher has taken to ensure that the findings of the study reflect the information that the respondents have provided, rather than the perception of the researcher (Lincoln and Guba ,1985). To ensure that this was done the researcher during the data analysis process had to read over the transcripts a number of times in order to grasp fully the main issues that have been raised in the interviews. The transcripts and audio recordings of each interview were the raw that had been collected by the researcher.

As soon as the transcribing of the interviews was completed, relevant passages were extracted from the text. This was followed by identifying the key themes and concepts and coding them to ensure a rich foundation to base the analysis on. This also made it possible to compare the findings and present rich data. Hereafter, all opinions, individual's personal experiences and comments were arranged according to the recurring, designated themes for all the interview transcripts. The process of arranging the coded data into common themes enabled meaning to be given to the experiences of African-immigrant car guards with regards to accessing health-care services in Durban, South Africa.

The themes ranged from one sentence to paragraphs. The main themes were then integrated in order to convey the analysis. The themes that had been set were reread and deduced in a manner that they provide insight into the everyday experience of African-immigrant car guards with regards to accessing health care services. Once the coding, translating and arranging of data was done the outcomes were described. This included the final analysis of results, making an argument with regards to the research questions and referring to the theoretical framework. The main findings are discussed in chapter five.

3.7 Ethical consideration

3.7.1 Permission and informed consent

The ethical approval for this study to be conducted was granted by the University of KwaZulu-Natal. A research proposal outlining the study, as well as a consent form, was submitted to the Ethics Committee of the College of Humanities at the University of KwaZulu-Natal before the study could be conducted. The University has a set of requirements that are outlined with regards to ethical matters. These were followed to ensure that the confidentiality and rights of the respondents were protected at all times. Before every interview was conducted, the respondent was informed about the aim of the study. It was also highlighted to the respondents that their participation was entirely voluntary. As a result of this, they had the right to withdraw from the interview at any moment, should they have so wished. Prior to conducting each interview, written informed consent was obtained.

3.7.2 Rapport

Rapport was built with respondents to ensure that they were comfortable enough to share reliable information. Issues of confidentiality were discussed at the start of each interview, which put respondents at ease. Respondents were assured that the information they shared with the researcher would not be passed on to another person but would be used purely for research purposes. They were further assured that their names would not be revealed. In addition to this, some of the questions were asked slightly differently (of the same respondent) during data collection, to double check that the respondent's responses were similar.

3.7.3 Confidentiality

The confidentiality of all respondents was kept and respected at all times. Interviews were conducted in a quiet area within the malls where the conversation would remain between the researcher and respondent, without other individuals hearing what was being discussed. Furthermore, respondents were given the reassurance that the information they were sharing with the researcher would be used only for the purpose of the study. No further information would be passed on to anyone before the release of the study. Every respondent was given a copy of the consent form, which was written in English and had all the researcher's contact details.

Furthermore, respondents were assured that specific individuals would not be linked to any comments or responses when the outcomes of the study were released. This meant that any information that would place the identity of any respondent at risk of being revealed had to be omitted in order to hide their identity.

3.8 Limitations

Qualitative research, like any other research method, has its own limitations. It is well known for being a very time-consuming method (Terre Blanch and Kelly, 1999). This has meant that the researcher has had to limit the number of interviews that could be conducted for this study. As a result, only 16 interviews were conducted in order to complete the study in a reasonable and manageable timeframe. The length of the interviews cannot always be restricted to a predetermined duration, which may lead to the respondents becoming agitated and irritated by any further probing. The interview process further requires the researcher to spend additional time transcribing the interviews, and sorting the results. Finally, the researcher must always bear in mind that trust has to be built between her/himself and the respondents. This enables the respondents to give her/him relevant information for the study.

It must be noted that the findings of the study are not representative of the whole population. They cannot therefore be generalized, or seen as representative of the entire population of Durban, the province of KwaZulu- Natal or even South Africa as a whole. The findings have not been tested as to whether or not they are statistically significant or due to chance. This

could conceal evidence of bias on the part of the researcher, which can be associated with self-reporting and the generalization of findings of the study. The study was conducted at only three of the well-known shopping centres in Durban, namely Queensmead Spar, Davenport Square and Pick 'n Pay Hypermarket in Durban North. It obtained the personal experiences of African-immigrant car guards and their ability to access healthcare services in Durban. The findings from this sample of car guards cannot be generalised for all African car guards in Durban or South Africa.

Self-reporting has been identified as a limitation when it comes to research (Terre Blanche and Kelly, 1999). This is based on the fact that it contains a certain element of bias to it, especially when it comes to African immigrants and the history of xenophobic attacks/behaviour that has taken place against them in South Africa (HRSC, 2008). Two of the respondents were very reluctant and uncomfortable when participating in the study. The researcher's experience was that once they had agreed to be part of the study, they either provided ambiguous responses, laughed with discomfort or repeated the same answer. The researcher therefore had to first reassure the respondents that none of their names would be given to any legal authorities. In addition, it required that the researcher rephrase certain questions in a manner that would make the respondents feel more comfortable, simultaneously ensuring that the overall meaning of the questions remained the same. This was done in order for the researcher to establish a level of trust with the respondents.

Other limitations can be related to the method of data analysis. Thematic analysis is a method that relies on the researcher's interpretation and could incorporate biases (Terre Blanche and Kelly, 1999). However, the analysis was conducted systematically according to codes in order to draw out themes emerging from the data, rather than the researcher's preconceptions. Verbatim quotes were used to support and enrich the synopsis of the identified themes.

Regardless of the limitations of the study, the findings provide an important insight into the accessibility of healthcare services for immigrant-African car guards. This study is not solely for African car guards to share their experiences, but also to identify the challenges that they, and possibly others, encounter when accessing healthcare services.

3.9 Conclusion

This chapter described the research methodology that was utilised in the study. The study made use of the qualitative method of research and used the thematic approach for its analysis process. It clearly outlined the study area and population that was part of the study. It furthermore, outlined the data collection process including the tools that were used to gather information and how and why they had been amended. It looked at the process that was undergone in order to obtain ethical consideration from the university as ensuring that respondents understood the purpose of the study, the rights they had when agreeing to being part of it, the signing of the consent form and how the identity of the respondents would be kept safe at all times. The limitations that can be associated with qualitative research were also highlighted in this chapter with regards to the ones linked to this study.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter outlines the findings of the study based on the experiences of African-immigrant car guards and their access to healthcare services. The findings have been presented in the following sub-sections: Characteristics of respondents, knowledge and awareness of healthcare services, personal experiences of accessing healthcare, perceptions of the public healthcare system, hindering factors to accessing healthcare services, suggested areas that still need improvement in the healthcare system, healthcare services most commonly used by males, healthcare services most commonly used by females as well as longing to go back home.

4.2 Characteristics of respondents

In total, 16 in-depth interviews were conducted, 14 with men and two with women, reflecting the gender profile of the occupation. Of the 16 respondents interviewed, 13 (81.3%) were from the DRC and three (18.7%) were from Rwanda. The age of the respondents ranged from 24 to 49 years, with the average age of the respondents being 38 years. More than two thirds (68. 8%) of respondents reported they were married, 18.7 % were single, and 12.5 % of the respondents were divorced. Only one respondent indicated that he did not have any children as yet. Even those who reported they were single had all had at least one child. All of those who were single stated that they were not living with their partners. The reason for this was that they still strongly believed and respected their culture which is against cohabitation. All interviews were conducted in English, as the respondents were all second-language English speakers.

Only one of the respondents indicated that he had a second job, other than that of car guarding. He noted that having a night-shift job was not easy, as being a car guard required him to be on his feet at all times. By the time the day was over, the only thing he wanted to do was to relax at home, but the need for additional money would not allow for this.

A total of six respondents reported that they had a second source of income within their household. All of these respondents were married. Out of these six respondents only one was a woman, and her husband did deliveries for Kentucky Fried Chicken. Of the five male respondents, two reported that their wives were working in hair salons, while one indicated his wife owned a small salon. One male respondent indicated that his wife had a small day-care centre, and the other said his wife was also a car guard. All of these respondents expressed that they felt it was essential for their wives to assist them when it came to accumulating additional income. This was motivated by the fact that the income from being a car guard was not enough to sustain their families.

Overall the level of education amongst the respondents was fairly high. All respondents had been able to attend formal school. The lowest grade that was attended was grade nine for those who had only been able to attend high school in their own country. Out of the 16 respondents, eight had been able to study at a tertiary-institution level, but only two were able to complete their degrees. For most of the respondents (87.5%), financial difficulties and the conflict in their country of origin had resulted in the incomplete studies. One female respondent expressed:

“I was only able to study until my second year of my nursing degree in Rwanda. These on-going wars have meant that we are unable to fulfil our dream careers. This has meant that we then unable to provide the type of future we had hoped for our children”. (Respondent 1)

A male respondent who had completed a psychology degree expressed:

“You know it’s very hard for us, by that I mean us foreigners to get a job in South Africa regardless of our qualifications. Rules and regulations of South Africa favour those of its citizens to being given first preference when it comes to getting jobs. Hence, I have had to resort to being a car guard to get some sort of income while I am here in South Africa”. (Respondent 12)

All the respondents indicated that regardless of having been able to attend upper high school and tertiary education, furthering their education in South Africa was not easy. The main reason for this, apart from challenges with getting study permits, was not having money to pay for fees. Even if they did have some money, having a family meant that family needs came before their own.

4.3 Knowledge and awareness of healthcare services

Not all respondents were aware of the different types of healthcare services available to them in South Africa. There was a sense of confusion when they were asked by the researcher about this. This was mostly the case with the male respondents. Several male respondents spoke of not being able to attend informative classes (teaching foreigners about their rights in the country, English classes and health related matters) at refugee camps, which placed them at the disadvantage of being unsure of the different healthcare services available to them. These classes were said to take place at the Emmanuel Cathedral in Durban at the Denis Hurly centre. This church was reported to have a clinic that refugees make use of. It is there that they are informed about available healthcare services. These respondents had sought employment straight away when they came to South Africa. Once they had found jobs, such as being a car guard, there was hardly any spare time for them to attend such classes. The two male respondents who had a medical background (in terms of tertiary education) were able to identify a number of services that should be routinely available in public health settings. One of these male respondents stated:

“Well, I know that some of these services are HIV/AIIDS testing, male circumcision, the treating of STIs, family planning, pre and postnatal sessions for women and the testing of cancer for both males and females”. (Respondent 15)

All 14 male respondents knew that they were entitled to HIV testing. They knew that they could get tested for free at any government / public clinic or hospital. One male respondent stated:

“Yes I am fully aware of my rights of accessing healthcare in South Africa. I know that it is my human rights to get all the medication, treatment and medical procedures I may need as a foreigner because it is written in the Freedom Charter. I have to be honest with you, I am not aware of all the services but I know that HIV testing is the main service we use as males. Male circumcision is not common amongst foreigners”. (Respondent 9)

The two female respondents were more aware of the type of services that were available to them and the right to accessing these services. One female respondent expressed:

“Yes I am aware of the healthcare services available to me. Like for example Primary Health Care...Um like when you have started at the clinic for example. Then from there will they direct you to the hospital if it’s very serious. When you do get to the clinic and you want to get HIV tested they will first direct you to a counsellor. They would even inform you on how to protect yourself from HIV/AIDS. Also, how could I forget family planning which is very important because they use to, and still say, foreigners have too many children. As much as they are emphasising family planning to everyone but I feel they are right - foreigners do have too many children. I think it goes back to the Christian belief that says you must have as many children as you can because God has said we must multiply”. (Respondent 1)

Another female expressed the following:

“I would have to say that the only reason I am aware of my rights is because they are written and posted on all clinic walls. Apart from this I can honestly say, I don’t think I would know them. Had I not seen them on the clinic walls”. (Respondent 2)

It was evident that most respondents were unable to define the term healthcare services or list any of the services offered. Respondents stated they were unable to do so because of having insufficient information on this.

4.4 Personal experiences of accessing healthcare services

All the respondents felt that their first experience of accessing healthcare in South Africa was satisfactory. This was based on the fact that firstly, respondents overall felt that South African health facilities were more equipped by more skilled health professionals than those of their home country. Secondly, respondents highlighted that there was sufficient medication and medical equipment compared with that of the hospitals they used in their home countries. One respondent noted:

“South Africa is a developed country and because of this it is way advanced when it comes to medicine and surgical equipment. You know that you will get the help that you need here and your chances of surviving are better. Unlike at home things are very tough there, we are short of medicine and equipment Apart from this we have very limited doctors who are not well trained as the ones I have seen here. I remember the very first time I went to a hospital, having being a medical student for

some time; I was impressed by the quality of advanced medical equipment in your hospitals". (Respondent 15)

Another said:

"The first time I went to a hospital here in South Africa was because I was involved in a car accident. I had injuries on one of my legs, but the service I got I felt was good. Why do I say this? I have to say because the nurses and doctors that helped knew what they were doing. I walked on crutches for a while but after attend physiotherapy session I was able to walk properly. If I had not told you about my accident you would not even know that I injured one of my legs, that why I say they're good". (Respondent 10)

However, a major concern that was raised was of the language barrier between them and the health professionals, apart from this there were no major problems. For most of the respondents their first use of a health facility was for their own health purposes. Yet, it was also the case that some respondents who had children used a health facility for the first time when their children were sick. Unlike the overall positive view of hospital services, these respondents reported that the health professionals were disorganised in these facilities.

Respondents who started off by using a using a clinic stated that based on their perception, there has not been much change in clinics since their first experience of using one. However, they did state that once they were exposed to hospitals they did prefer using them over clinics. The reason for this was that respondents felt hospitals were more organised and equipped with all the medical equipment and treatment to assist them with any illness. Those respondents who started off using hospitals felt that the service they received was still good, although from time to time nurses were experienced as rude. A respondent had this to say:

"If I had to pick between using a clinic or hospital, I would with no doubt pick the hospital. The nurses there are much more professional; they are willing to help you more and are more welcoming than those in clinics. Please do not get me wrong, I am not saying all nurses in clinics are rude because people are not the same. However, I have noticed that they are less friendly than the ones in hospitals". (Respondent 13)

4.5 Perceptions of healthcare services

4.5.1 Thoughts of the public healthcare system

There were mainly two types of thoughts about the South African health system. Some of the respondents felt that the public health system was not a good one. This was based purely on the fact that they thought that the health professionals lacked passion for their jobs, which resulted in them treating their patients with a lack of compassion. Respondents complained about being neglected by nurses when requesting help. Some of them stated that they have witnessed their friends or a family member being ill-treated by nurses when they were at hospitals during visiting hours. A respondent expressed below:

“I remember accompanying the mother of my child to the hospital she was in labour pains. When we got there the nurse told us to wait. The mother of my child was even crying, I just felt so helpless. When I asked the nurse to attend to her she told me that she is busy with something but she is coming. I just felt that we were not being given attention with such a delicate issue”. (Respondent 16)

However, regardless of this a few respondents did acknowledge that maybe the cause behind this treatment could be that the clinics and hospitals are under staffed, that it could be this pressure that may be causing the nurses to react in such a manner. A respondent stated:

“I think people don’t understand that it is not easy being a nurse. The pressure that they may face from being under staffed causes them to be frustrated. Please do not get me wrong, I am not saying treating patients in a disrespected manner is good. I am just saying let us remember that they are also humans and they do make mistakes or have a bad day once in a while”. (Respondent 1)

Complaints were also raised about the reception areas of clinics and hospitals. Respondents stated that it is often the case, mainly at clinics, that you arrive and you are not attended to. Being attended to was said to have taken a long time in some cases. One male respondent expressed:

“The manner in which some nurses do things [that] just makes me ask myself is, do they still even care about their jobs and the way they treat us. I mean, some of them just don’t seem interested in their jobs anymore. How can you be busy drinking tea

and laughing when seeing that someone is in so much pain, and not see the urgency to assist them”? (Respondent 11)

One respondent stated that, overall; the public health system of South Africa was a good one. The only major concern that he has with it is the level of hygiene. He raised the point that hospitals should be kept clean at all times, as infectious diseases can spread really fast in such conditions. The respondent did however emphasize that it is not all hospitals that have issues of poor hygiene. The two hospitals that were said to have this problem were Addington and King Edward hospitals. By contrast, King George V and Albert Luthuli Hospitals were given credit for their level of hygiene.

Further concerns were raised regarding the period that one has to wait for an operation booking to take place. An example that was given was regarding waiting for a tonsillitis operation. The challenge here was that it could take up to two years for one to get an appointment date. If it happened that this appointment was missed, for whatever reason, one would have to start all over again and rebook. The respondents thought that the reason for this was that there are only a limited number of doctors, many of whom were thought to be also working in private hospitals at the same time. A female respondent stated:

“I have to say, what I have notice[d] about the South African health system is that it is very hard, or should I say, a booking of an operation in a public hospital takes forever. This is the major challenge I have notice[d] when it comes to surgical operations being done”. (Respondent 2)

South African hospitals were identified as being under staffed by many of the respondents. A female respondent stated that maybe more students should be allowed the chance to study medicine in order to address this issue. However, she highlighted that one thing that has come to her attention is that there are many opportunities in South Africa but they are not made use of. She made a comparison of the education system, using mathematics as an example. She stated:

“If you take a look at how students back at home study, [it] is totally different. And the technology – because when you do maths you find that you will be using the calculator and computer, at home it’s not like that. You go to the exams they will say don’t use the calculator for the first hour. Then after that they will say okay come and take your calculator. Or they will say start with the one that needs the calculator but

by the end they would have said stop you must submit the calculator. Then you just have to start calculating from your head. The reason for this is because they found that people become very lazy and they don't want to use their brains. Furthermore, I think parents should attempt to teach their children, for example how to read, and not fully rely on the educational system". (Respondent 1)

The public health system of South Africa was further identified as one that was not very accommodating of foreigners. This was based on the fact that language has been identified as being a major barrier for many foreigners on their first encounter at a public clinic or hospital. Some respondents felt that the South African government should intervene with this to ensure that communication between immigrants and health professionals is facilitated when healthcare is sought.

Alternatively, the public healthcare system has been identified as being a good one. This was indicated by all of the respondents who stated that South Africa is a developed country. This implies that it has all the necessary equipment and medication when it comes to the provision of healthcare. Two of the male respondents stated that they had been in a car accident a couple of years ago. They were highly satisfied with the operations that were conducted on them – they felt that they were a success. One of these male respondents commented:

"South African surgeons are well trained, I have to say. I mean, I have never had to go back to hospital after my operation on my leg. Yes, for a few months I was walking with crutches but I was attending my physiotherapy classes. I then, after that accident, was involved in another one and there also I received good treatment. It is hardly the case that your operation will give you problems. It is because of this that I think the health care system is good. I mean, it can never be hundred percent good but it is fairly good". (Respondent 10)

Some of the respondents who have not been in South Africa for more than four years have never had to use the clinic or hospital. They have mainly relied on the use of pharmacies. These respondents felt that the pharmacies were highly organised based on the fact that the moment you entered one you were attended to straight away by a shop assistant. These shop assistants were said to have been very welcoming and helpful. Respondents reported having been asked questions regarding the symptoms of their illness, when it started, if they had taken any alternative treatment, and so on. Respondents emphasised the fact that they have

never had to wait in long lines for hours, but kept on emphasising the great service that they received. The following quotation is by one of the pharmacy users:

“I have never been to a South African hospital, but about the chemists I can say that they are very good. I can say because the people you explain your problems to at the help desk or entrance don’t need you to even give him money or something in return for their help. He or she does it because they love their job”. (Respondent 12)

Respondents stated that because of the wars that had taken place in their home country, there has been an increase in the level of corruption. This corruption has even flooded into the health sector. Getting health assistance has come with favouritism where for example, if you have a family member who works at a clinic, they would give you first preference regardless of whether or not you were in the line. Furthermore, because of the limited medication it was necessary to bribe in order to receive strong medication. In South Africa this was not the case, there was no need to bribe in order to receive assistance.

Accessing healthcare was not seen as a challenge for all the respondents. None of them have ever been denied access to healthcare when requesting it, because they have the correct paperwork. However, respondents highlighted that it becomes a major challenge to access health care if you do not have your refugee documentation. They knew of many friends who had had this problem. They have had to revert to the use of pharmacists and buying medication over the counter when they are not well. Respondents felt that if a person has a passport from the Congo, it becomes easier to go to a General Practitioner and pay them for their service. A male respondent noted:

“I know a few of my friends who have gone to a General Practitioner with their passport because of being very sick at the time. It is something that has been done and my friends have received the help that was needed”. (Respondent 10)

4.6. Hindering factors of accessing healthcare services

4.6.1. Language

The greatest barrier to accessing healthcare services for all respondents was the issue of language. Most of the respondents were unable to speak English when they came into the country. As a result of this, many of the respondents had to rely on a friend or family member

to accompany them when going to the clinic or hospital. These associates would then translate to the health professional what the problem at hand was. As much as this was assisting the respondents in terms of getting medical attention, some respondents felt uncomfortable about disclosing certain medical information in front of their friend. Yet these respondents stated that there was nothing they could do because they required the medical attention. One respondent stated:

“You know, there are things you just wish you could keep to yourself. As much as you have known someone for years but you need your privacy. I felt very uncomfortable as we were sitting and waiting for the HIV/AIDS test results with one of my friends and the nurse. I was praying the whole time for the outcomes to be negative. I mean, he’s human – he could have passed on the information to one of our other friends before I was willing to disclose my status if it was the case that it would be positive”.
(Respondent 8)

As much as this was not easy, the respondent further stated that it is the urgency of knowing your medical status that becomes more important than anything. Some respondents were not as fortunate as to have a friend to accompany them to the clinic or the hospital. These respondents stated that it became very difficult to communicate with the health professionals. All they could truly do was point to the area where the pain was coming from. At times the nurse would start becoming frustrated at them because of his/her failure to understand what the respondent was attempting to communicate to them. One respondent stated that some nurses would try to keep calm and others would just start shouting at them:

“You cannot speak English? You cannot speak isiZulu? How am I meant to help you?” (Respondent 14)

One respondent who was able to speak English stated that many of the foreigners form new friendships in such cases, where a foreigner who was in the queue would witness such a case and intervene to assist both the nurse and patient. She reported that this did not just occur in clinic and hospital queues; it was also commonly the case at queues at the DHA. Long friendships have been formed from such encounters. The respondent indicated that she felt that some foreigners were under the assumption that they were being ill-treated by the nurses because of not being able to speak English. Yet, she felt that this was not entirely the case – language became a barrier and on its own caused both parties to become highly frustrated. It

was not because the nurse was ill-treating the patient because they were a foreigner. She further stated:

“I mean, by the time you have waited so long in the line and get to the nurse you are both frustrated. I mean, she has been working the whole day and most probably under the conditions of being short staffed and you on the other hand think she is taking forever to do her work. Then when [they] have to start communicating with you both of you are unable to hear each other. That just sounds like a recipe for disaster to me. Hence, you find that some foreigners say nurses treat them badly because they’re foreigners, but fail to see things from the nurse’s perspective”. (Respondent 1)

4.6.2 Health provider

A clear differentiation was made between the health professional staff at the clinics and hospitals. Those who worked permanently in clinics were said to have a lack of patience. They were further seen as disorganised in the manner in which they ran the clinics. Respondents had great concern about the manner in which the reception area was controlled. Some of the respondents stated that when you arrived at the clinics the nurses there seemed to lack interest in attending to them. They would take long tea and lunch breaks and not seem to be majorly concerned when seeing patients that were very sick. Respondents felt that they were made to feel as if they had to beg to get assistance for a human right they were entitled too. This was not just the experience of the respondents – it was the case for all patients at the clinics. However, those respondents who have been in the country for over five years stated that the level of bad treatment from the nurses has become much better. Respondents reported previously overhearing the nurses referring to them as ‘*amakwerekwere*’ (a pejorative term for foreigners), but that it is now rare that they would hear such comments being made about them.

By contrast, nurses who worked in the public hospitals were said to be more patient with the respondents when it came to the issue of language as a barrier. They have been placed in the same category as the health providers at pharmacies. Both of these health providers have been said to be very helpful and welcoming by respondents. One of the male respondents stated:

“You know there is that sense of hope you get when you are ill and the nurse is giving you all the required attention. As well as when you can see that she is

concern[ed] with your well-being. You became encouraged that you will get better sooner or later”. (Respondent 16)

Another said:

“Even getting a smile from the lady at the help desk goes a long way. Her reassuring you that the nurse or doctor will be with you shortly encourages you to bear the pain just a little bit longer”. (Respondent 15)

It is evident from this that foreign patients are aware that language is a major obstacle when it comes to them accessing healthcare services. However, regardless of this there is still a major expectation from them that they be given the required help when seeking healthcare services from health professionals.

4.6.3 Coping strategies during difficulties of accessing healthcare service

Most of the respondents employed similar coping strategies when it came to dealing with the challenges they encountered accessing healthcare services. The commonly used coping mechanism was to submit themselves to the nurses and remain as calm as possible. This was regardless of whether or not the nurse was getting irritated or frustrated by respondents' inability to speak English. What was essential was receiving the required health care, regardless of the social treatment that accompanied this. Most of the respondents that had this attitude stated that giving off a bad attitude to the nurses would not make things any easier but would raise frustration levels. This would result in them not receiving the help that they may have required. These are some of the quotations that clearly illustrate the thoughts of the respondents:

“The attitude you come with is very important in order for someone to help you. I use to do as they would tell me; because the fact is I needed their help. Getting angry would not help me feel better whereas the medication will”. (Respondent 3)

Another stated:

“You know, if you want something you don't have to be rude. That will only make it harder for you to get help...you need to submit yourself in order to get the help that you need, to get what you want. So you have to be humble in order for someone to help you. That's the type of attitude I had at all times when I went to the hospital”. (Respondent 6)

A few respondents stated that they employed the strategy of forming friendships while waiting to be attended to. They felt that having someone with them who would be able to explain their problem in the correct manner would, firstly, ensure they obtain the correct medication and secondly, would lower the chances of the nurses getting frustrated by the language barrier.

One of the male respondents stated that he employed the strategy of waking up very early so he could be one of the first people in the queue. This would ensure that he would receive the assistance he required, unlike those individuals who arrived at midday and became irritated by the fact that they sat the whole day at the clinic or hospital and were never attended to. He stated:

“When you know that you need help you need to wake up early in order not to wait in the long lines. If you wake up early you are going to be in the front and finish early”.
(Respondent 5)

Only one respondent stated that he believed in standing up for himself when he saw that he was not getting the required assistance. This stemmed from the fact that he had two young children. He had never had to be admitted to a hospital, but his children had had to. He understood that some people would never understand his frustration, until they ‘put themselves in the shoes of a single father of a three and four year old’, after which they would also react in his manner. He further expressed himself by saying:

“You have to stand up yourself and ask where you can go to get help. It is only then that you will get the help you need. You just have to force yourself through to get the help that you require and not fully rely on them to take care of you. If you expect that they are going to attend to you so late, by then you are going to be very frustrated and irritated”. (Respondent 11)

It is evident that the respondents generally felt that the best coping strategy is to remain calm, regardless of the type of treatment they may be subjected to. What was of great importance was receiving the required healthcare service.

4.7 Suggested areas that still need improvement in the healthcare system

The study revealed that all the respondents felt that the South African public health system was fairly good and required minor changes to the way in which it operates. Much emphasis was placed on the improvement of the reception areas, mostly among clinics. Respondents felt that this was a critical matter as the reception area is the first point of contact between the patient and the health professionals. This first encounter had a great impact on the mental well-being of those respondents seeking health care. It either gives them a sense of hope or discourages them.

The respondents suggested that more workshops be done with the -service staff, to assist them with the challenges they may encounter in their jobs as government officials. This may assist with fast tracking the process of receiving resources that health facilities may be short of. Moreover, health professionals should from time to time have counselling sections where they are able to offload all the emotions and frustrations they go through daily as their jobs are not easy. The ultimate goal of this would be to revive the passion that health professionals once had regarding their jobs. One respondent stated:

“You know, maybe it is easy for you to sit and judge nurses in clinics because we don’t understand the pressures they may face. I think it is important that they also get emotional support because they see so many depressing things daily, after all, they are humans too”. (Respondent 3)

Another said:

“I do not just speak to South Africa[n] nurses, but African nurses all together. I believe that our nurses, by that I mean African nurses, face so many pressures. Support structure need to be made for them because they play a very important role in us maintaining our health status”. (Respondent 9)

Furthermore, respondents felt that there had to be a restructuring of the reception sitting arrangements. Respondents raised concern that there was no assistance with regards to the sitting arrangements. In a number of instances respondents had joined a queue, only to find out once at the front that no more patients would be assisted on that day. Respondents felt that there needed to be an individual who is responsible for directing patients in terms of

where to sit, and grouping patients according to what they had come for. One respondent stated:

“ You know for example they could group all those who are there to see the doctor from a previous appointment, those who might have a flu to see a nurse, those who need counselling in one room and so on. It just becomes so disorganised when we have to keep on asking the person in front of you where to go when they themselves are not [quite] sure”. (Respondent 2)

Respondents also felt that the strategy of allocating a certain nurse and doctor for these groups could be of much assistance. For example, one nurse could deal with attending to those who are coming to the clinic for the first time. He/she could assist them with the filling in of their clinic card and file. From there he/she would be able to direct the patient to the relevant waiting room for their medical issue to be attended to. Furthermore, respondents felt that this would also assist health professionals themselves in determining how many patients they would be able to assist daily.

A few of the respondents raised the concern that you can end up sitting the whole day at the clinic in the hope that you are going to be helped, whereas, as a result of the long queue you may not be assisted at all. Employing a system of ticket numbering, where only a set number of people are given tickets, could also assist with this. . Once all the tickets have been issued no more tickets would be given out. This would also give the health professional's time for things such as stock counting, packaging of medication and the checking and updating of their records. Moreover, respondents also felt that the South African government should increase the number of health professionals that it has. A female respondent said:

“I really think they should try bringing in more doctors for children in clinics and hospitals. I mean, there is nothing as painful as seeing your child very sick and having to wait a long time because of the limited number of doctors. I could try bearing the pain because I am old but a child just becomes so helpless.” (Respondent 1)

Respondents further felt that hospitals and clinics should employ at least one translator who is able to speak different languages. This would assist both the patients and the health professionals when language becomes a barrier. Respondents acknowledged the fact that when you are in a new country it must become your own responsibility to learn the new

language. However, this will take time and during that period of learning translators would play a critical role.

It is clear that respondents felt that health professionals work under stressful conditions and that this influences the development of negative attitudes towards their jobs. Hence, the respondents suggest improving the public healthcare system to ensure that health professionals work under conditions that will encourage them to be more efficient.

4.8 Most commonly used healthcare services by males

All male respondents stated that they did not go often to clinics or hospital. The main reason for this was that they did not get sick that often. Even if they did get sick, it would be something minor such as the 'flu' or a headache. In these circumstances respondents opted for buying over-the-counter medication at pharmacies. Male respondents further stated that the commonly-used-health services amongst them were that of HIV/AIDS testing. Respondents highlighted that because of the HIV/AIDS pandemic occurring in Africa, HIV/AIDS testing should be encouraged more amongst males. This was based on the belief that males are mostly likely to have more than one sexual partner at a time. The male respondents further expressed that they have been raised to know that ensuring that their health is good at all times is essential. As a result of this the respondents felt that there were hardly any circumstances that would hinder African males from accessing health care service. One male respondent stated:

“We are not afraid to get medical help no matter how sick we are. Even if it means I am told to take off all my clothes for a medical check-up, I will do it. It does not make me less of a man in any way. Instead it makes me a responsible male, which we lack more of these days”. (Respondent 14)

Doctors were identified as being more helpful than nurses by the respondents. They were described as more patients when it comes to issues such as the language barrier. All the male respondents felt that healthcare services were highly accessible in South Africa. Their view was informed by the use of X rays, physiotherapy sessions, screen testing for migraine headaches, HIV/AIDS testing, access to the pharmacy and the dentist at the hospital. The above-mentioned services were those the male respondents said they had used at some point in South Africa.

4.9 Separate questions for females

One of the two female respondents that were interviewed had three children. The other respondent did not have children, but stated that she had had one child; however, it had passed away. She further stated that she would prefer not to go into detail regarding what had happened to her child. Her child was not born, and did not die in South Africa. This respondent became very emotional when she was talking about this.

The respondent with three children indicated that they had all been born in South Africa at King Edward Hospital. The respondent had received both antenatal and postnatal care for all three pregnancies. She received information about HIV/AIDS at the required monthly check-ups for herself and the baby during and after each of her pregnancies. She had to attend weekly prenatal classes that had been set for her by appointment. Her first child was delivered by caesarean section due to it being a breach baby. Her second baby was delivered by emergency Caesar due to her not being able to push the baby out during a natural delivery. Her last baby was also a caesarean delivery. Immediately after her last delivery she requested a tubular ligation to be done as she did not want any more children. She stated:

“Raising children is very expensive now. We just cannot afford to have anymore; I mean, it is hard enough raising the ones we have now”. (Respondent 1)

She further stated that she attended postnatal sessions after each birth. The respondent said this was very important because her wound could be checked, as well as her overall healing process. She commented:

“You know, checking your wound from the caesarean is very important. I know a few people who have passed away from getting infections and because of failing to take care of their wound, by not cleaning it and all. So, I made extra sure that I took care of mine”. (Respondent 1)

Both the female respondents indicated that they undergo a Pap smear examination once a year, as recommended. The respondent with children said that she had also done family planning. However, she had not planned to have her second and third child. She stated that she started bleeding on and off after the use of the injectable contraceptive after she had had her first child. It was during this period that she fell pregnant with her second child. After giving birth to the second child she started using the contraceptive pill. She suffered from

tonsillitis and was prescribed antibiotics; the use of which she believed interfered with her contraceptive cycle. However, she did acknowledge that she had forgotten to take her contraceptive pills from time to time.

It was interesting to find that all the married male respondents attended the birth of their children. They stated that they encouraged their wives to go for prenatal and postnatal care appointments. This was to ensure that their wives experienced good at all times.

4. 10 Longing to go back home

All of the respondents stated that their migration to South Africa was due to the political wars that have been taking place between the DRC and Rwandan government. Some of the respondents fled their home countries because they no longer wanted to be in a situation where political parties were in constant (violent) conflict. They felt that the only way that they would be able to find peace was by moving to another country. The rest of the respondents were victims of the war, in which they had lost a family member or their entire family. Hence, they fled to South Africa for their own safety. These are some of the quotations that were captured regarding the reasons for coming to South Africa:

“Actually my husband is coming from a political family. His older brother was a soldier and a colonel. So there are many issues, like with Congo, Rwanda and the M 23 [March 23 Movement] which are also known as the Congolese Revolutionary Army. My husband refused to go to Congo and to join the M 23. After that there was a huge misunderstanding and problems. After that we had to make means of leaving the country. Some of my husband’s brothers were also killed and because of that we just had to run away”. (Respondent 1)

“I came to South Africa three years ago, being 2010, because of the political wars. These political wars are an on-going problem back home. The reason I also come to SA is because my uncle got killed during the war. He was my only family. So I decided to come to SA for my own safety. I can say it was not so easy to come into the country at the borders. So when I came into the country I made sure that I got my papers from the as a refugee”. (Respondent 12)

Respondents stated that the journey to South Africa was not an easy one. It was a long and dangerous trip for many. It meant that those respondents who were part of political parties

had to use indirect routes to South Africa. Most of these respondents were those who have now been in South Africa for eight to ten years. The journey required that they bribe police officials to not arrest them along the way. Once they made it into the country, they ensured that they went to the DHA to arrange the required documentation as proof of their refugee status. Those who took the direct route stated that the officials at the border line did not make their coming into the country easy. Some respondents witnessed foreigners not being granted the chance to come into the country because their reasons were not judged as valid. However, respondents stated that it was much easier at that time to get refugee papers, than it is now. Their impression is that the officials have become stricter now. This is what some respondents had to say about the journey:

“It was very hard at the time because we were not using the direct routes, but we made more use of the short routes. We were stopped by the police a few times and we had to bribe them in order for them to let us go. At the time even bribing for paperwork once you reached the Home Affairs in Johannesburg was easy”.
(Respondent 14)

Another said:

“I remember that when we were in Zimbabwe we had to beg for food at one point because we didn’t have any money with us. We had to do a lot of hiking from truck drivers to make the journey faster but at times we did travel by foot for miles. It was very hard, I have to say, but what could we do”. (Respondent 6)

When asked why they came to South Africa, rather than other countries, respondents stated that South Africa – unlike other African countries – takes in refugees and asylum seekers. Countries such as Mozambique do not have refugee camps. However, while Zimbabwe also has refugee camps the respondents expressed that the economic conditions were not ideal there, and they did not support the way its president was running the country. South Africa became the country of choice firstly, due to the belief that it was the most developed country in Africa, and secondly, because it came with a greater level of freedom for refugees. A respondent had an interesting comment to make in this regard:

“Here in South Africa, it’s a big country and out of the rest of African countries there is so much development [as well as] the refugee places. Like Zimbabwe, it has refugee camps, but the people there are suffering. Here in South Africa, there is so much

freedom. In Zimbabwe you have to work within the refugee camps and if things are bad there life is bad. Here we are free because if I want to work I can work; if I want go to town I can go". (Respondent 11)

Having undergone the long journey and obtained refugee status in South Africa, many of the respondents stated that if it were up to them they would go back home. Firstly, this was because some of them felt that they could understand the frustrations that South Africans may be experiencing due to the number of foreigners that are now in the country. They highlighted that they themselves have seen how areas such as South Beach in Durban have become more populated with foreigners over the years. In essence, they understood that the issue was around resources and that South Africans were entitled to feel as if they were being overburdened by the increase, over the years, in the number of foreigners.

Secondly, some respondents stated that they had been well established 'back home'. They previously had had successful businesses back home. Those who had attended university had envisaged themselves completing their degrees and starting their families knowing they could sustain them. However, this has not been the case, with many having had to leave all that behind, and settle for working in the informal sector in South Africa. This is the only sector that is willing to absorb them. A respondent who is a father of two said in a very saddened tone:

"Do you know how heart breaking it is to know that I spent four years studying for my accounting degree back home because I wanted a good life for my children? Look at me now; I am a car guard, with a qualification that I cannot even use right now. I am suffering with a qualification". (Respondent 4)

Respondents highlighted that if only South Africans could take the time to understand the struggles and sacrifices they had gone through, maybe they would be more considerate towards them. This makes it evident that migration comes with challenges for those moving into the new country, and for the citizens of the country.

Thirdly, most of the respondents who had children feared that their children would grow up not knowing their culture in the correct and full manner. As much as they could instil certain teachings regarding their culture as parents, for their children not being in the psychical

surrounding and experiencing this first hand will always be a downfall. Some respondents had this to say:

“You know at times I look at my children and the life that they are adopting. I mean, the way in which they do things is not the way we use to do them back home, it is not their culture. I become fearful that my children may never experience being in their home country and how life is without the wars. That there is part of them they will never be exposed to”. (Respondent 5)

Another said:

“The funny thing is that we [the DRC and Rwanda’s citizens] do not hate each other. It is our governments that have issues against each other. I mean, we have even lost track of what the war is about now. At time I miss home, I wish I could show my children where I was raised, where I use to play as a child but I cannot because of the wars”. (Respondent 1)

It is unmistakable that for many African immigrants the journey to South Africa with the intention of safeguarding their lives has been an unsafe one. This study has revealed that foreigners are aware that they are being questioned when it comes to whether or not they would ever return to their home countries. For many, if circumstances in their home countries were not prohibitive, this would be the case.

4.11 Conclusion

The findings of the study reveal that accessibility to health care services for African immigrants has become easier for them over the years. Most of the respondents reported that they access to health care as satisfactory. However, most of the male respondents were not aware of the available health care services to them. Respondents highlighted that language still serves to being the great barrier of accessing health care in the country. This challenge was greatly encountered when respondents made use of clinics then that of hospitals. Furthermore, respondents felt that some South African health professionals lacked passion which resulted in patients been treated with a lack of compassion. Moreover, none of the respondents stated that they have ever been denied access to health care when they sought it. The findings demonstrated that the respondents had no structured coping strategies that assisted them with the challenges they encountered when accessing health care services

CHAPTER 5: DISCUSSION AND CONCLUSIONS

5.1 Introduction

This chapter discusses the findings of the chapter. The purpose of the study was to explore the experiences and perspectives of immigrants employed in the informal sector, with regard to accessing health care services in Durban, South Africa. The principle theoretical framework that will inform this study is the Andersen (1968) model of health-care utilization. The model has three categories which have been identified as determinants that would drive an individual to utilization of health-care services. While the study had a small sample of African immigrant car guards, it is not generalised to the whole population of African car guards, and it has demonstrated substantial results.

5.2 Discussion

The majority of the respondents in the study were not aware of the healthcare services that are available in public health clinics. This was particularly the case among the male respondents. Most stated that the reason for this was due to being unable to attend any of the information classes for refugees. Once they were in South Africa, their priority was finding employment or another source of income in order to support themselves and their families. Most of the respondents stated that it was easier to find employment in the informal sector than in their area of expertise. This was a similar finding to the USA DRC refugee caseload study. It found that while immigrants in their caseload had considerable skills and work experience, when they looked for employment in the USA they ended up employed in the informal sector rather than in the area of expertise they possessed (U.S Department of State, 2012).

Some respondents have had to rely on friends and family for information on how to go about accessing healthcare services in the country when they ill. This is linked to the need factors component of Andersen's theory (1968). As reported in this study, where the family or a friend has seen that there is an illness that has to be attended to, they have resorted to accompanying the respondent to a healthcare clinic or hospital on numerous occasions. It became apparent that the occurrence of illness and both the availability and belief in the health facilities prompted the family or friend to accompany the respondent.

Respondents reported their personal experiences of accessing health care as being satisfactory. This was based on their experience that South African health professionals were seen as being more skilled than those in the respondents' home countries. Thus, respondents felt they were in good hands when being assisted by the medical staff. Furthermore, respondents acknowledged that South Africa had a larger variety of medication available than what they could receive or have prescribed to them in their country of origin. Respondents felt further encouraged to make use of health facilities as there is seldom a shortage of medication in South Africa, compared to the situation in their home country. Nevertheless, a number of respondents preferred to purchase their medication over the counter as they felt this was more convenient for them, and they received more assistance from the pharmacies. These findings can be related to the enabling characteristics of Andersen's model (1968) which outline that an individual who believes that the healthcare services are useful, with regards to the treatment that will be received, will most likely use the available services. As such, the belief in the skills of health professionals and the surplus of medical provision in South Africa is a contributing factor to respondents making use of healthcare services and facilities. This is linked to the walk-in policy and being able to access medication with ease. Due to the availability of medical stock, it is perceived as being useful by the respondents. Respondents noted that the South African public transport was very effective compared with that of their home countries, making it easy to access health facilities.

Respondents reported still facing several challenges when accessing healthcare services. The findings of the study demonstrate that language barriers remain one of the challenges for respondents when accessing health care. They have had to rely on friends for assistance. This sometimes was uncomfortable for the respondents as they had to disclose personal information in front of their friends. These findings coincide with Crush and Williams (2001) who stated that migrants, particularly those who have limited English proficiency, are usually less satisfied with the healthcare services that they receive.

Furthermore, health professionals who worked in clinics were regarded as being less patient than hospital staff when dealing with the immigrants' language barrier. However, respondents did acknowledge that this may be due to understaffing in these facilities, and not merely due to the immigrants' nationality. This is related to the perception of the need for health services, whether individual, social, or clinically-evaluated perceptions of need. However, migrants continue to access healthcare services as they perceived the health system would still serve them, regardless of language barriers that exist.

What was of great interest was that literature mentioned the stigma and discrimination that migrants face in their host country. In a study conducted on immigrants in the USA, it was found that predominantly immigrants were reporting discriminative acts against them in the healthcare setting, compared to non-migrants (Monga, Veller and Venters, 2014). However, there were no findings in this study to echo this – respondents identified a change in the attitude of health professionals in this regard. This contrasts with previous research which has shown that immigrants have been subjected to discriminative attitudes from health professionals. Instead, this study found respondents stating that in the last couple of years they have not experienced much stigma and discrimination associated with health professionals. The respondents felt that the ‘attitude’ of health professionals, referred to by some immigrants, may be as a result of health professionals being overworked as a result of facilities being understaffed. Therefore, the working environment for nurses, rather than stigma or discrimination, was identified as the major reason as to why nurses may not be so friendly.

However, some respondents felt that the South African public health system could not be perceived as a good one. This was based on the fact that they thought that the health professionals lacked passion for their jobs, which resulted in them treating their patients with a lack of compassion. Some of the respondents associated this as being directed mainly at immigrants. Respondents complained about being neglected by nurses when requesting help. However, literature presented by Atagaba, Akazili and McIntyre (2011) states clearly that the South African healthcare system is faced with a number of challenges, including factors such as understaffing, poor infrastructure, inequitable health care and shortages of medication, amongst others. In prior research South Africans themselves have complained about the type of service they receive from health professionals (Atagaba et al., 2011), thus demonstrating that the frustrations with limited staff are not experienced by immigrants only, but at the population at large as this is a current issue that health sector is faced with.

All of the respondents in this study stated that they had never been denied access to healthcare services. In fact, those respondents who have been in South Africa for more than five years reported that, in their view, there has been a decrease in discriminatory behaviour and a shift in attitudes among health professionals. Thus, issues of stigma and discrimination are not validated by these findings. Studies done in Canada contrast with this study’s findings, in that there are still cases where refugees and immigrants are being denied access to emergency and basic care in Canada (Oxman-artines, Lacroix and Hanley, 2005).

This has been associated with the lack of medical insurance coverage for foreigners in Canada. Furthermore, studies conducted on immigrants in the USA found that reporting on discriminative acts against patients in healthcare facilities were predominantly from immigrants (Monga, Veller and Venter, 2014).

Respondents acknowledged that immigrants who did not have legal documentation still face challenges when it comes to accessing health care, although none of the respondents mentioned witnessing any illegal immigrant they knew of being denied access when seeking healthcare services. However, a study conducted by CoRMSA highlighted that undocumented immigrants still face challenges of being denied treatment due to a lack of documentation or recognition of the documentation they possess (CoRMSA, 2009).

The findings in the South African literature coincide with those of a study done on over 11 European countries that found that undocumented immigrants still face challenges when accessing health and other vital services. Being an undocumented immigrant has further been found to be costly as they experience not only discrimination, but also have to pay high service fees (Commission of the European Communities, 2008). This concurs with Andersen's theory (1968) where he highlighted, in his enabling characteristics, that if an individual is not medically insured the chances of them making use of health facilities are minimised. Both the literature and the findings of this study have been in line with Andersen's (1968) theory.

The study demonstrates that the respondents had no structured coping strategies that assisted them with the challenges they encountered when accessing healthcare services. The common coping mechanism that was used almost across the board by the respondents was of remaining calm regardless of the type of treatment they were being subjected to. Respondents stated that as long as they had received the required medical treatment they paid little attention to the challenges encountered while accessing healthcare services. One fundamental limitation, however, in the literature concerns the limited information on coping strategies that have been used by immigrants when encountering challenges of accessing healthcare services.

5. 3 Theoretical Framework

Up to this point, only two factors/characteristics of Andersen's theory have been discussed. These include 'enabling' and 'need based' characteristics. The study's findings are also

linked with the last factor of the theory, 'predisposing' characteristics. It is apparent that all the respondents form part of the informal sector and were not members of a medical scheme or insurance put into place for its employees or their families. They were, therefore, largely limited to using public health facilities. This shows how the use of health facilities that can be used are impacted by social status.

All of the respondents were Christian and believed only in the use of Western medicine. Thus, if the respondents did not go to a clinic or a hospital they would only make use of pharmacies. Furthermore, Ziemke's (n.d) study recognises that Congolese believe in the use of Western medicine. According to his findings, the Congolese were both accepting and considered Western medicine to be effective. Thus, regardless of any illness that a respondent or their family member had, respondents made use of healthcare facilities as they believed in the South African health system.

This study found that there is a relationship between an individual's level of education and knowledge of health services available. Those respondents who had been enrolled in tertiary education were able to list some of the health services that they know are available to them. For those who could not complete high school this was a challenge. Furthermore, the study found that health utilisation was influenced by the age and gender of the respondents. The wives of the respondents and the two female car guards that were interviewed were of a reproductive age. Thus the married car guards and the husbands of the two female car guards had no choice but to make use of healthcare services from time to time as certain child-related services would be needed during this period. Following the delivery of their children husbands would also have been responsible for taking the children for vaccinations and so on if the wife was busy. The religion of the respondents and health beliefs were truly rooted in the use of Western medicine. Thus, even male respondents believed in seeking medical assistance whenever they were ill. The male respondents stated that they saw no shame in being assisted by a female nurse regardless of the illness they might have.

It is evident that Andersen's (1968) model of healthcare utilization has been appropriate for this study. All three factors of the theory have been found to have links to the study's findings. What could be identified from the findings as a short coming in the need based characteristics was the lack of knowledge that the respondents had about the healthcare service available to them. This was found to be a challenge mostly amongst those who did not have any form of tertiary education.

5.4 Study limitations

The respondents in the current study were African-immigrant car guards. A limitation that had not been foreseen at the outset was that 14 of the respondents would be from the Democratic Republic of Congo (DRC) and only two from another African country, in this instance Rwanda. The population sample had been expected to be one of immigrants from a diverse range of African countries. The fact that the sample was dominated by one ethnic group could have influenced the findings of the study to some extent, in particular because they shared the same health beliefs, religion and a similar understanding (norms) of what their day-to-day way of living should be like. Thus, the findings are more likely to reflect this majority view, rather than that of diverse nations.

The sample was made up mainly of male respondents who reported little need of healthcare services. This was purely because the car-guard sector is dominated by males. Other studies which have had more females in their sample groups have shown they are likely to access healthcare services more regularly. The findings of this study could have been different had the sample been balanced out in terms of the male to female ratio. While this study was based on a moderately small sample of African-immigrant car guards from three of Durban's shopping centres, and cannot therefore be generalized to all African-immigrant car guards in South Africa, it was nonetheless able to reveal numerous notable results.

The only data collection constraint that was identified was the limitation of office spaces. The interviews had to take place either on a bench next to the parking area or under a tree with shade that was close by to the parking area. However, this did not have any major constraints on the information provided by the respondents; it only required that the tape recorder be paused when individuals were passing close by.

5.5 Recommendations and policy implications

Healthcare-utilisation research for immigrants is essential as migration has been identified firstly, as one of the fastest ways diseases are spread, and secondly, as a human-rights issue. Hence, the following recommendations may go a long way in the quest for a lasting solution in terms of accelerating healthcare utilisation by immigrants in South Africa.

5.5.1 Implications for practice

South Africa is a diverse country in terms of the number of languages that are spoken in it. Furthermore, it is becoming increasingly diverse as more ethnic groups are moving into the country. This study highlights that efforts should therefore be made by the government, governments of African immigrants and the Department of Health (DOH) to train interpreters on languages most spoken by African immigrants, such as French. Moreover, the South African government should not only rely on these stakeholders, they should take further steps to work with international NGOs. This will assist the DOH to serve a broader population and have visible reach. These interpreters should be placed at a number of clinics and assist those immigrants who are still unable to communicate in English. This would be a start to dealing with the language barrier that has been found to still be flourishing.

Our current health-professional sector is one that is understaffed and encountering several challenges. Thus, orientation should be conducted for health workers on how to uphold the ethics of the profession and on the fundamental values of human relations to improve services. Hence, it is essential that from time to time health professionals receive training that equips them to deal with challenges in the health sector.

5.5.2 Implications for future research and policy changes

In the future, advocacy campaigns could push for a policy shift that focuses more on ensuring that enables immigrants to become fully informed about protocols, healthcare facilities and services available to them. This could be done by targeting residential areas that are populated by African immigrants, with the use of interpreters. Future research studies could also select communities in which a number of these campaigns could be instituted over a period of time. However, these areas will have to be those with a clinic or hospital nearby. Any changes in the utilisation of the health facilities by immigrants in the area, as a result of these campaigns, can then be evaluated. Policy makers need to take into consideration that there are social factors that influence the use of healthcare services, as seen from Andersen's model. Until these have been addressed, the utilisation of health services is always at risk. Government must ensure that it addresses the grievances of immigrants in a tangible way. This can be achieved through research and consulting with organisations that work on a daily basis with immigrants.

5.6 Conclusion

South Africa has one of the most progressive healthcare systems in Africa. However, the study revealed that the language barrier is still a major challenge for many immigrants when utilising health services. With the increasing volumes of migrants moving into the country, the health systems continue to face a number of constraints. This is a major challenge as the current health system is currently understaffed. This is something that the government, governments of African immigrants and the DOH need to have discussions on in order to uphold the health rights of immigrants as is stipulated in the constitution of the country. This will require the cooperation and participation of all of these stakeholders.

The study revealed that male respondents make less use of healthcare facilities than do women, as research literature has continued to show. The reason for this is that males prefer to make use of fast, on-the-go medication that can be obtained from pharmacies. This is done with the aim of avoiding long queues and the time consumed at clinics. As the respondents stated, this time could be used for work hours instead. The study argues that little attempt has been made by the South African government in ensuring that immigrants are informed about the protocols of accessing health care in the country. Thus, there should be more focus directed to this, particularly as research has stated that migrants are able to transfer new diseases into host countries with ease. It can therefore be concluded that immigrants are able to access healthcare services. However, what remains as a hindering factor for some is not being well aware of the healthcare services available to them.

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Appendix 1: Interview Schedule

Migration and Health Care: exploring the experiences of immigrants employed in the informal sector in Durban, South Africa.

Section 1: Socio-Demographic characteristics

1. Could you please specify the following:
 - 1.2 Age:
 - 1.2 Gender:
 - Female
 - Male
 - 1.3 Where were you born?
 - 1.4 What is your home country?
 - 1.5 How long have you lived in South Africa?
 - 1.6 Marital status:
 - Married
 - Divorced
 - Widowed
 - Never married
 - 1.7 What is your highest level of education?
 - 1.8 Aside from your work as a car guard, what other source of income do you have?
 - 1.9 What were your reasons for coming to live in South Africa?
 - 1.10 Do you ever long to go back home?

Interview questions

Section 2: Personal Experiences

1. What do you understand of the term healthcare services?
2. When did you first go to (government) healthcare facility in South Africa?
3. Please describe where you went?
4. What happened?
 - Probes:

What was the attitude of the security staff at the facility?

What was the attitude of the nurses at the facility?

What was the attitude of other people waiting at the clinic?

5. Did it meet your expectations? Probe: Why? Why not? How?
6. From the first encounter, have your experiences of accessing healthcare services in South Africa changed in any way? If so, how?
7. What are the types of health care services that are available to you in South Africa that you know of?
 - Probe:
How have you come to know about them? If no, why are you not aware of the healthcare services available?
8. What are some of the healthcare services that you have used in South Africa?
9. Which of the following do you use the most?
 - Public hospital
 - Clinic
 - General Practitioner

Section 3: Perceptions

10. What are your thoughts on the public healthcare system of South Africa?
11. In your opinion, do you feel it adequately accommodates immigrants? Probe: why?
12. What do you think can be done to improve the public healthcare system?
13. What are some of the things that you like about the South African public health system?
14. What are some of the things you dislike about the South African public health system?
15. Do you think it has become easier or harder for immigrants to access healthcare services in South Africa?

Section 4: Hindering factors

16. Are there any particular factors that you would say have hindered you from accessing healthcare services?
17. Could you please rank these factors from the highest to the lowest with them hindering the accessibility of receiving healthcare services.

Hindering factors to accessing health care	Rank

18. What are your thoughts about health providers at health facilities?
19. What have been your coping strategies for dealing with difficulties in accessing health care? Probe: for any alternative means taken when not able to access healthcare services?
20. What are some of the ways you believe these hindering factors towards accessing healthcare services can be eradicated?

Awareness

21. Are you aware of your rights to accessing healthcare in South Africa? Probe: If yes, what are they? If no, why not?

Section 5: Separate questions for females

1. What health services do you use most commonly?
2. Do you have any children? If yes, how old are they?
3. Were any of them born in South Africa?
4. Did you seek and/or receive prenatal care during your pregnancy? If yes, what was your experience with health providers during the check-ups? If no, why not?
5. Where did you give birth?
6. Who assisted you during your birth delivery?

Probe: how was this experience?

7. Did you seek and/or receive postnatal care?
8. Have you visited a health facility for other sexual reproductive matters?

Probe: What were these?

Section 6: Separate questions for males

1. Out of these services which one have you used?
HIV/AIDS testing, circumcision, STI testing, TB testing, blood and urine analysis, testosterone screening, fully body check-up?
2. Were you present during the period that your wife/partner was giving birth?
3. Were you aware of whether your wife/partner attended both prenatal and postnatal care?
4. How often do you use healthcare services?
5. What health services do you use most commonly?
6. Are there certain things you consider before you go to a health facility if you're not well?
7. How accessible do you feel these services are to you?
8. What do you think are some of the perceptions that hinder African-male immigrants from accessing health care?
9. Do you feel health care providers play a role in this? If yes, in what way?

Appendix 2: Informed Consent Form

(to be read out by researcher at the beginning of the interview; one copy of the form to be left with the respondent; one copy to be signed by the respondent and kept by the researcher.)

My name is Snegugu Lerato Mchunu (student number 208509437). I am a Population Studies Masters student researcher enrolled at the University of KwaZulu-Natal Howard College Campus. I am doing a research study entitled, Migration and Health Care: exploring the experiences of immigrants employed in the informal sector in Durban, South Africa. This study is focused on exploring the experiences of African immigrants with regards to accessing healthcare services.

This study is supervised by Dr Kerry Vermaak at the School of Built Environment and Development studies, University of KwaZulu-Natal. I am managing the study and should you have any questions my contact details are:

School of Built Environment and Development Studies, University of KwaZulu-Natal, Durban 4041, South Africa.

Cell: 0837678401

Email: 208509437@ukzn.ac.za.

Thank you for agreeing to take part in the study. Before we start I would like to emphasize that:

- your participation is entirely voluntary;
- you are free to refuse to answer any question;
- you are free to withdraw at any time.

The interview will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report but I will not use your name.

Please sign this form to show that I have read the contents to you.

..... (signed)

..... (date)

..... (print name)

Appendix 3: Declaration by participant

I (full names of the participant) hereby confirm that I understand the contents of this document and the nature of this research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from this project at any time, should I desire to.

I consent/ I do not consent to this interview being recorded (if applicable).

Signature of the participant

.....

Date

.....