Spaces, Places, and Migration: Understanding and Strengthening Public Health-Care Provision in South Africa

Tackson Makandwa[1]

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Abstract

Given South Africa's historical and contemporary realities of both internal mobility and migration from other countries, this paper argues that engaging with space, place, and migration is pivotal to understanding and strengthening public health-care provision in South Africa. This paper views place as emerging from and relating to space. A mutually reinforcing and reciprocal relationship between people and place over time shapes health-care delivery and health outcomes in South Africa. Therefore, this paper argues that engaging with a place-based approach is required to understand the local context in which diverse groups are situated. There is, however, a lacuna in studies situating South(ern) African public health-care challenges within such a place-based approach. This paper presents findings from a mixed-methods study that was designed to fill this gap. The research team conducted fieldwork in six health-care facilities across two provinces in South Africa – four in Gauteng and two in the Vhembe district of Limpopo province – representing urban, peri-urban, and rural settings. The study included exploratory in-depth interviews with 77 health-care providers (including nursing and administrative staff), a survey conducted with 229 health-care users, and site visits. The findings show how diverse spaces shape and are shaped by different migrant profiles, producing diverse places, which in turn present particular demands to the public-health system. It is crucial to understand the pathways, behaviors, and meanings associated with such mobility if we are to strengthen the provision of health-care services in South Africa.

Keywords: migration, place, space, public health-care, Gauteng, Limpopo, South(ern) Africa

[1] African Centre for Migration & Society (ACMS), University of the Witwatersrand, South Africa
✉ tacksonmak@gmail.com

INTRODUCTION

One of the main migration routes for African migrants who undertake an array of migration journeys is in the southern African region (Makandwa and Vearey, 2017; IOM, 2023). The region has a long history of population movement and this has been a central and defining feature of the region's politics, economy, and culture (Crush and Williams, 2005; Crush and Tawodzera, 2014; Lurie and Williams, 2014). Migration and mobility in southern Africa represent a key livelihood-seeking strategy. However, such movement raises concerns about the health of both those who move and of the local (non-migrant) population (Vearey, 2018). Walls et al. (2016) and the International Organization for Migration (IOM, 2023) note that South Africa is the greatest recipient of migrants from the southern African region. These higher levels of mobility, both from across South Africa's borders and within the country, have placed demands on social services including public health care (Landau et al., 2011). Due to its relative wealth and perceived economic and political stability, South Africa plays a key role in migration on the continent and experiences high levels of mixed (regular and irregular) migration (Makandwa and Vearey, 2017; Misago, 2019), mostly from neighboring countries, the Horn of Africa, and West Africa (Frouws and Horwood, 2017).

According to the United Nations Department of Economic and Social Affairs (UN DESA, 2019), there were 4.2 million migrants in South Africa in 2019. This constitutes about 7.2% of the entire population. With Gauteng province estimated to experience the largest inflow and outflow of migrants between 2016 and 2021, inflows are estimated above 1,6 million (Stats SA, 2018). Cross-border and internal migrants are concentrated in Gauteng province's urban and peri-urban spaces (most international migrants settle in Gauteng – 47,5%). A high concentration of migrants is also found in the border areas of the Limpopo province (Vearey, 2014; Stats SA, 2018; Patrick et al., 2023). Limpopo province is home to many Mozambican and Zimbabwean migrants due to geographical proximity to the two countries (Landau and Segatti, 2009). Vearey et al. (2018) note that although both internal and cross-border migrants are unevenly distributed across the country, the majority of cross-border migrants are located in Johannesburg, Cape Town, Durban, and the Vhembe district (a district in Limpopo province that borders Zimbabwe).

Despite increased regional migration and mobility, as well as a growing politicization and securitization of migration, its impact on health systems is little understood (Walls et al., 2016). The discourse of migration within the Southern African Development Community (SADC) is dominated by cross-border migration, leading to discussions of immigration management and border securitization (Vanyoro, 2023). In South Africa, securitization with regard to migration is not limited to border control but also extends to the (increasing) securitization of health-care and communicable diseases surveillance (Hunter-Adams et al., 2018). However, there is substantial diversity in arrival routes and patterns of mobility and migration (including internal mobility) in the region, which results in heterogeneous

groups, and is often neglected in migration discourse (Vearey, 2014). The biased focus on cross-border migrants, neglecting those who move within the South African borders means that the real root faced by the health-care system remains far from being addressed.

Migrants can face distinct health needs depending on their legal status and migration journeys (AU, 2021). Migration within the SADC region has a long history that includes forced migrants fleeing conflict, individuals moving in search of improved livelihood opportunities, asylum seekers and refugees, traders, and seasonal workers displaced within their own countries or moving across borders (Schockaert et al., 2020; Mbeve and Ngwenya, 2022). Such diversity creates a unique context in which distinct, locally-relevant health responses are needed (IOM, 2011; Vearey, 2014).

The extent to which migrants' health care is addressed in policy frameworks varies greatly across countries in Africa (AU, 2021; WHO, 2022). The World Health Assembly (WHA) resolution A70/24 (WHO, 2017) highlights the need to adequately address the health-related requirements of migrants in line with the aim of the 2030 Sustainable Development Goals (SDGs) agenda of leaving no one behind. More importantly, it calls for nation states to address the needs of migrants and refugees in an inclusive, comprehensive manner and to respond to the health needs of the overall population in any given setting (WHO, 2017). It states that health systems should be migrant and people centered with the aim of delivering cultural, linguistic, gender, and age-responsive services – migrant-aware and mobility competent (WHO, 2017). Furthermore, Vearey et al. (2018) note that health governance has a significant part to play in tackling the challenges encountered by nations dealing with both internal and international migration. In line with the WHA resolution, access to health care in South Africa is constitutionally mandated for all, including migrants, regardless of their documentation status (Sprague, 2010; Walls et al., 2015). The 1996 South African Constitution, as interpreted within the National Health Act (2003), guarantees rights to access health care for everyone in South Africa and also provides for the right to dispute resolution (Makandwa and Vearey, 2017). However, there is a clear gap between policy and practice, and regional, local, and facility variations in how the legislation is interpreted (Walls et al., 2016). Given the potential for discrimination and gatekeeping within the public-health sector, this places health-care practitioners and those at the frontline in public health-care facilities as critical mediators of policy implementation (Walls et al., 2016). In the Gauteng province, for example, the provincial Department of Health (DoH) developed guidelines on how to treat non-South African patients that arguably confuses rather than clarifies the situation by erroneously defining foreign patients – who should be charged full fees for hospital-level services – as including refugees and asylum seekers. The law is clear: documented refugees and asylum seekers should be means-tested in the same way as South African citizens. However, maintaining free access to services at primary level is often regarded by practitioners as being the cause of increasing

workloads, undermining working conditions, and allowing some patients to abuse services available to them (Walker and Gilson, 2004). This may lead to the erosion of health-care provider morale and induce negative attitudes toward patients, because free access is viewed as increasing workload.

THE RELEVANCE OF SPACE AND PLACE FOR MIGRANT HEALTH CARE

In this paper, I focus on the process and interaction between people and place – how place influences people, how such places are also reshaped by people over time, and the bearing of this on health and health-care delivery in South Africa. I locate the concepts of space and place within migration, to explore and understand health-care provision in South Africa. These two concepts aim to illuminate and complicate how the health-care provision can be understood. They help conceptualize the study sites as both physical and social spaces and ascertain their impact on health-care delivery. The concepts of space and place have long histories with a multiplicity of meanings and interpretations (De Certeau, 1984; Jones and Moon, 1993; Kearns and Joseph, 1993; Massey, 2004). In this paper, place is viewed as emerging from and relating to space and used as a lens to understand South Africa's health-care challenges. Where space is regarded as a site that is unfixed, contested, and multiple (Massey, 1994), place is viewed as having more structure and fixed meanings, and it implies an indication of stability (De Certeau, 1984; also see Jones and Moon, 1993). It is in places that people become who they are – growing older, working, learning, and maintaining their health or becoming unhealthy (Kearns and Joseph, 1993). Whether in rural or urban areas, the unique qualities of places contribute to the contours of people's health status and health-care service delivery (Kearns, 1991). The relevance of place for health variations is that it constitutes and contains social relations and physical resources (Jones and Moon, 1993; Cummins et al., 2007). Thus, places are sites where people can interact with multiple determinants of health, including with health-care systems.

Engaging with a place-based approach is required to understand the local context in which diverse groups are situated. Moreover, identifying possible places of vulnerability arising from migratory flows allows us to shape appropriate health-care responses in South Africa. This includes understanding the diverse health risks, benefits, and vulnerabilities that face heterogeneous migrant groups (Vearey and Nunez, 2010). In viewing places as symbols of the heterogenization of the world, Bruslé and Varrel (2012) argue that migration and migrants change space and create places that reflect origins, migration routes, and the relation of migrants to their host community. In this study, this is reflected in how migrants interact with the public health-care system. A number of authors assert that research on health and place should not separate context from composition, because there is a mutually reinforcing and reciprocal relationship between place and people (see, for example, Kearns, 1991; Jones and Moon, 1993; Kearns and Joseph, 1993; Cummins et al., 2007). Context and composition are important explanations for health inequality

and why the association of place with health outcomes has been found to remain relatively weak, as individuals influence and are influenced by conditions in multiple places on a daily basis, and over their lifetime (Cummins et al., 2007).

Using data collected in six primary health-care facilities, this paper is based on the premise that understanding the local context(s) in which diverse groups live, work, and transit through can assist in strengthening public health-care system responses to meet the needs of all users – both local and foreign – in South Africa. More importantly, in the wake of migration and mobility, xenophobia, increased difficulties in accessing basic social services, and an already compromised public health-care system in South Africa, I argue that places are symbols of understanding and strengthening public health-care provision where individuals (migrants and non-migrants) interact with the health system. The interplay between places and people's movements leads to places (including regions, localities, and particular facility settings) affecting people's health, and, in turn, individuals themselves shaping places (including services and their provision). A range of health-care actors – migrants, non-migrants, health-care workers, and managers are influenced by and shape services (Walker and Gilson, 2004). Thus, I argue that place is an important lens through which to understand migrant health-care dilemmas in South(ern) Africa, including responding to migration, access to health care, treatment continuity, service delivery, and the population's health status.

METHODOLOGY

This paper is based on qualitative data drawn from in-depth interviews conducted with health-care providers, exploratory surveys conducted with health-care users, and visits to six primary health-care facilities in Gauteng and Limpopo provinces in South Africa. The researcher selected the facilities to represent urban, peri-urban, rural, and cross-border settings. For each of the two provinces, a team of researchers conducted in-depth interviews with health-care providers and surveys with health-care users. The team interviewed 77 health-care workers, which included a mix of clinical and administrative staff, ranging between 10 and 14 participants per facility. These in-depth interviews were conducted in private settings within each clinic. There were 229 survey responses (30–40 health-care users per clinic), which included 127 South Africans and 102 non-national patients. A random sample of patients, who were queuing at each clinic, were invited to participate in a short, administered survey. Their place was saved in the queue and the survey was administered in a private setting, most frequently an empty consultation room. After every facility visit, the research team wrote detailed field notes. The survey responses allowed participants the opportunity to provide detailed narratives of their encounters within the particular clinic or any other South African clinics and hospitals. The research team conducted observations of clinical settings, which formed part of the detailed field notes. Furthermore, the team recorded and transcribed the interviews. Data analysis consisted of thematic content analysis, which began with the research

team identifying major themes and sub-themes at a three-day workshop. This allowed transcripts to be reduced into relevant themes and quotations arranged in table form to allow for cross-interviewees and cross-site comparisons. Narratives from the surveys and quotes from the in-depth interviews and field notes provided relevant themes and quotations for this paper. To support these findings, the team identified representative quotations. The research was approved by the University of the Witwatersrand Research Ethics Committee (non-medical), the London School of Hygiene and Tropical Medicine Research Ethics Committee, and the relevant Provincial and District Health Departments.

RESULTS AND DISCUSSION

Within the fieldwork context of those seeking health-care services, diverse labor and personal profiles emerged: these included (but were not limited to) migrant and mobile workers (e.g., truck drivers and contract workers), local resident women, and those who were crossing borders, including in some cases for health-care reasons. These groups present health-care demands ranging from maternal health-care services, to HIV/AIDS services, and treatment for other chronic conditions, including tuberculosis (TB) and high blood pressure. From the analysis of health-care user surveys and health-care provider interviews five main themes were identified: migrant health-care users and service delivery; increased workload; health-care system displacement; crime and safety; and the challenge of return migrants.

Migrant health-care users and service delivery

First, I discuss the range of health-care users that we identified and their impact on service delivery in the fieldwork sites. This theme highlights the realities of migrants and mobile populations whose lives are embedded in multiple places, the realities of host communities, and the interactions between the two populations (Acevedo-Garcia and Almeida, 2012). People move for a variety of push-pull reasons. This has a differential impact on health profiles and service delivery, including medication shortages (caused by return migrants at the end of the year, as well as cross-border migrants coming for seasonal work and upsetting stock planning), communication challenges, patients having multiple consultations for the same medical condition across various health-care facilities, difficulties with continuity of care, and challenges ensuring that patients complete courses of medications.

Shortage of medication is a challenge facing most public health-care facilities, as they struggle to treat large numbers of patients within their catchment area. The majority of health-care providers reported that such medication shortages are worsened by increasing numbers of non-nationals. For example, a doctor from Vhembe district, responding to the question of whether inward migration contributes to shortages of medication said:

> Yes, it does, because we find that, for example, Mozambican people come and consult, consult in a large number. So, when the local patients, when they come – remember the clinic is for local people – when they come to consult, they find there is no treatment [i.e., medication], the treatment is finished (doctor, rural clinic).

Such a response is underpinned by deep-seated stereotypes about cross-border migrants in South Africa as abusing resources and overburdening state systems to the detriment of the local population (also see Vearey, 2014; Maphumulo and Bhengu, 2019). By appealing to us to "remember the clinic is for local people," the doctor points to both perceived resourcing implications about migrant populations and also exhibits a lack of understanding of policy guidelines relating to their care, given that "local people" are perceived by this particular doctor to exclude migrants. Such negative perceptions regarding cross-border migrants were widely held. Another example was provided by a nursing sister from another facility in the Vhembe district:

> The people from outside, they abuse medication sometimes … because you can see if the patient comes, last we were using booklet, you can see a patient comes today, tomorrow is coming here at the clinic, another day she goes to [name of place] that clinic near here ... For a week, the patients circle all around clinics around [this area]. They want to collect medication. I don't know what they do, but they used to … ya, others say rumors, say they collect medication and they go that side with it, maybe to give [to] their relatives" (nurse, border area).

Such presumed "shopping around" for medication, combined with other forms of perceived misuse by cross-border migrants, is said to result in a shortage of medication in public health-care facilities. These behaviors were also reported (though no evidence was provided) to be taking place outside of the public-health system, whereby cross-border patients who had financial resources were reported by some health-care providers as consulting with private doctors and buying medication. Again, this emphasizes the strongly-held perceptions of public health-care providers that position non-nationals as abusers of the public health-care system. One explanation for this behavior is that patients have a distinct lack of trust in the nurses and the health-care system more generally and resultantly seek out various treatments in the hope that one facility will help them. While this behavior is not confined to migrant populations, health-care providers clearly consider it to be particularly problematic when it is undertaken by migrants.

Similarly, a service provider at a peri-urban facility in Gauteng revealed how cross-border migrants and mobility generate further visitors (e.g., relatives), obligations, and demands for services in public health-care facilities:

> Because this is an industrial area, so there are many traveling firms. Yeah, so they travel with trucks and stuff so we get some people who come in here and collect their medication. The truckers, yeah, and then they leave. And most of the women, because they come in here maybe to visit their husbands because they live in Zimbabwe or Mozambique and stuff, and then they get free access to health [care] and then they leave to another country (nurse, peri-urban facility 1).

These scenarios generate situations whereby health-care users are accused by health-care providers of abusing the free access to health services available. However, data on whether such abuses are actually taking place is limited. Our survey results (reported elsewhere) do not support these suggestions of "shopping around" or abusing the public health-care system.

Migration and mobility give rise to interactions of ethnic groups, diverse languages and cultures within public health-care facilities. Language and communication become a challenge and, in such instances, immigrants' experiences are those of discrimination and denial of services otherwise granted to nationals (Acevedo-Garcia and Almeida, 2012). In this study, health-care users faced the challenge of language ability and effective communication and this could give rise to denial of services, restricted access, and poor-quality treatment. Moreover, language and communication abilities impacted on cross-border patients' access to health-care services and affected the quality of services within that setting, including privacy and confidentiality. A nursing sister in one of the Gauteng peri-urban facilities talked about the biggest challenges facing the clinic and clinicians:

> ... language, it is a struggle. Because you cannot obtain what is wrong from the patient because you know mos [it's like], they have to tell us what is wrong. And again, the confidentiality of them but, and in such cases I have to go out there in the crowd and [ask]: "Please, who is from Malawi here, and do you know English?" "Yes." "Are you sure you understand English?" "Yes." "Then please can you come and translate?" (nurse, peri-urban facility 2).

In some cases, migration and mobility present challenges for treatment continuity for HIV and other chronic conditions and follow-up consultation across facilities. For example, at the rural facility in Vhembe, there was concern that contract workers residing in the area temporarily and those using a facility in the border town, were either visiting for medication and then returning home to Zimbabwe or visiting en route to further destinations. The concerns raised relate to the ability of users to continue to access treatment once they had finished their contract and moved to another location.

Increased workload

Respondents in the fieldwork localities regarded migration and mobility as generating significant additional workload. Problems arising from presumed increased patient numbers and what were considered transient populations were compounded by insufficient staff ratios, high staff turnover, and delays in replacing them. Such pressures have a huge impact on workforce morale. One respondent at a Vhembe facility said:

> … shortage of staff, yes, because we are seeing more patients, especially from outside, only here at [border town] the border. All people from Africa, they start here, to get here at the border. So, we're seeing many patients, the ratio is too big. Ya, it affects health services ... too much overload and staff shortage are the biggest challenge here … we have not received training on migrants. It has had an effect on antenatal care services, because they move from that side [Zimbabwe] to deliver here. They come for antenatal care and to deliver here; they bring their babies for vaccination … Ya, because it's free (health-care provider, border area).

Workload considerations are interrelated and may generate a vicious circle; in fact, staff shortages in facilities gave rise to resignations of overworked staff. Park Station, the primary railway station in inner-city Johannesburg, provides travel connections to the whole of Africa. A health-care provider in this locality offered his opinion (which he could not verify but which reflected the views of other staff members) on the impact of the migration on the clinic:

> Yes, I think they're overworked, some of them. Because the location of the clinic, it's in a transit point. There's Rea Vaya [bus service], there's [transport terminus]. Yes, there's a bus terminus for buses for all over Africa. And then the clients are too much, so sometimes they [the staff] get burned out. I think that's why they resign (health-care provider, urban facility).

Respondents observed that the combination of a greater number of patients and under-staffed facilities, as well as the nature of the workload generated by migrant populations, brought their own particular difficulties. This includes additional demands on maternal health-care services (antenatal care, delivery, and immunization services). However, again this was expressed in interviews as a perception of the impact of migration on the facilities rather than being evidence-based. South Africa provides free health care to women during pregnancy and children under six years (Silal et al., 2012; Makandwa and Vearey, 2017). A health-care provider in Gauteng province's peri-urban informal settlement facility said:

> I am just thinking, maybe in their country, maybe they do pay when they're pregnant for deliveries and all those things. So, they decide to come this side because it's free (health-care provider, peri-urban facility).

Health-care system displacement

Aside from availability and cost, when selecting facilities, migrants were motivated by perceptions of treatment quality. A decision to use a particular facility was frequently linked with poor service being previously experienced at another facility. These experiences included verbal abuse from professionals and fellow patients, being denied service, and what users perceived as poor-quality services. For example, we were told that most health-care users using one of the peri-urban clinics did so as a way of avoiding perceived poor-quality treatment from nearby facilities (field notes, November 21, 2015). Verbal abuse and denial of services were widespread, but not necessarily limited to the experiences of non-nationals. It occurred to patients traveling from outside the facility catchment area and where staffing was stretched. One patient at an inner-city Johannesburg clinic spoke about her experience of being denied services:

> I was verbally abused. I came with my child [who] was sick and I was from work. But they said I was not supposed to come to the facility and they told me I am not the only patient here. … Waiting long is always a problem; besides having many people, the staff is slow. I was told that my stitches were not to be removed here; I have to go to this other clinic in the city (local patient, urban facility).

This patient's narrative illuminates a number of service-access and quality dimensions, including that users have to report to facilities early, endure long waiting times, face overcrowded environments, and that staff are perceived as slow and overworked. Poor communication between health-care providers and patients was further detrimental to service experience. One service provider recounted a patient's experience from one of the provinces:

> Nurses at the border clinic four times took blood samples from him but always failed to give him the results – his results were always "pending" – he ended up going to a hospital in the border town because he was not getting any help at this clinic (health-care provider, border area 2).

Similarly, another service provider, referring to the same clinic, said:

> She gets her ARV pills at the border clinic because she started at this clinic; but if she wants to be treated for other illnesses, she doesn't come to the border

> clinic, she goes to other clinics. Every time she experiences a problem at the border clinic. She calls it "Satan Clinic" (health-care provider, border area 3).

A further contributor to patients moving between clinics was a wish for privacy. For example, providers identified that some teenagers seeking family planning assistance at a peri-urban clinic from a nearby informal settlement in Gauteng, avoided a mobile clinic in the informal settlement. Some patients were willing to travel significant distances to be treated at a facility that could safeguard their privacy and ensure confidentiality and thus avoid potential stigmatization, particularly for those being treated for HIV/AIDS. This exchange between an interviewer and a nursing sister highlights this problem:

> *Nurse, peri-urban facility*: No, even the locals you know [residential location] is 30 minutes. They are driving; they travel by train, a taxi to come here. So, they've got … they get lots of transport to come this side. They prefer to come to [peri-urban clinic].
>
> *Interviewer*: So, why do they prefer this clinic [peri-urban clinic] over a clinic in [residential area]?
>
> *Nurse, peri-urban facility*: When we ask them, they start, [peri-urban clinic] is far, you know, no one will know their [HIV/ AIDS] status …

Such privacy and confidentiality concerns raise questions about the continued stigmatization of HIV (Gilbert and Walker, 2010). Users' reasons – in this case even the citizens' reasons – for changing facilities and their treatment preferences could be an indication of financial and staffing shortfalls within the public health-care system. As Coovadia et al. (2009) observe, South Africa's health-care system and health-service delivery continue to be shaped by the country's controversial past, including racial and gender discrimination, violence, and severe income inequalities.

Crime and safety

Reciprocal relationships between people and place that shape health delivery and outcomes are influenced by perceptions and experiences of crime and safety. A necessary condition for clinical safety and service quality is that health-care facilities are secure sites. South African experiences of migration and mobility largely focus on urban areas, and these are overrepresented in the crime statistics, thus allowing a connection between migration and criminality to be made despite the lack of evidence to support such claims. However, concerns of crime and safety were issues that were often raised during the research and respondents indicated that these were not confined to urban areas. Within the study context, some patients expressed concerns around safety and a fear of being robbed when they walked between

their residences and the health-care facility. This fear was amplified by staff delays – one health-care user at a rural facility in Vhembe district suggested that delivery bottlenecks and waiting times could increase the risk of becoming a victim of crime in localities surrounding the clinic:

> … they neglect patients and ignore patients at the clinic. [Staff are] very slow in assisting and treating patients; patients stay very far, so will walk late to their house. Often thieves will steal their handbags because it is very late (health-care user, rural facility).

Clinicians and health-facility employees also expressed fears for safety in the work location, and this sometimes led to them undertaking lengthy daily commutes from their rural homes rather than residing near the facility. Such commuting patterns have the potential to contribute to staff burnout. Fears expressed by health-care providers from different locations, suggest a widespread impact on health-care delivery. One nurse from Vhembe district rural facility pointed out:

> We cannot offer a 24-hour service because the nurses' home is not completely secure. There is not enough light outside, because nowadays there is a lot of crime. You cannot move from the nurses' home to the clinic where there is not enough light. Somebody can come and tell the security, "I have got someone who is ill," whereas can you see our fence, it is near the main road. Somebody can start there and shoot through whereas we are staying and moving here … (nurse, rural facility).

Similarly, a nursing sister from an informal facility in the Gauteng peri-urban setting revealed how safety and the location of the facility can impact on service coverage and staff retention:

> No. I think the only time the staff that goes [resigns from post], is the dental, one because this place, you know, is a Colored area, so they swear at you, they will tell you, "I'll wait for you, I will stab you." So, there's a white lady who was working that side, a dentist, so they said to her, "We'll shoot you and we're going to take your car. You won't get out of the gate." So, she got so scared; then she just decided, "I'm no longer coming" (nurse, peri-urban 4).

Fear of crime and feelings of insecurity may thus contribute to high staff turnover, long commuting distances, and, in some cases, the closure of particular departments.

Challenge of return migrants

Alongside cross-border migration, there is widespread internal migration where people move locally between provinces. This has received scant attention in the

literature and yet internal migration occurs far more frequently in South Africa than does cross-border migration (Vearey, 2014). Health-care providers within a rural study site in Limpopo province perceived that return migrants, mostly traveling back from Gauteng province, contributed to the spread of diseases and unwanted pregnancies:

> *Health-care provider, rural facility*: Ja. When they come back home during [the] festive season, there are a lot of people, and if people are many, there are a lot of activities and even the diseases. It's increasing.
>
> *Interviewer:* So, what kinds of diseases? So, you mean the increase in the community?
>
> *Health-care provider, rural facility*: About the STIs [sexually transmitted infections] and other problems. The teenage pregnancy, it's a challenge also, and of course, now the HIV and AIDS. When people are in Gauteng, they met a large number of people. Gauteng is very busy. So, about the cross-infection, [it] is very easy there.
>
> *Interviewer*: So, people then come back here over holidays and then you see the numbers of STIs and pregnancy?
>
> *Health-care provider, rural facility*: Because I know when they come back, they left their wives around here. And when they are in Gauteng, there are other families there, so you see there is a lot of cross-infection. And some are working in mines or where they acquire TB, and so on. And when they came back, they met with those around here and they become infected.

Some interviewees made assumptions of certain places being morally corrupt and contributing to the spread of sexually transmitted infections, including HIV/AIDS, which fit with prevailing place stereotypes. Gauteng, for example, in this study is viewed as a focal point of all social ills. More so, migration is often perceived as a catalyst for extramarital affairs and polygamous marriages, contributing to sexually transmitted diseases (Gilbert and Walker, 2010). Such scapegoating may place blame on return migrants as sources of infection and disease, while downplaying the role of the local non-migrant population.

Return migrants were also blamed for affecting the operations of health-care facilities in rural areas. Rurality complicates the ways in which return migrants are able to access supplies of medication and to attend follow-up consultations at facilities. Health-care providers in Vhembe district highlighted struggles to provide medication, especially antiretrovirals (ARVs) and other chronic treatment during festive holidays, as relayed by this respondent:

> Yes, it does, because when they come, you find out that some of them have finished their ARV treatment, their chronic treatment. When they come here, they expect chronic treatment from you, and you find that the clinic has ordered a certain amount of treatment for people around. So, when they come here, they have to, you can't deny to give someone treatment and they don't even bring anything for them, they just bring the treatment (health-care provider, rural 2).

This demonstrates how health-care policy, organization, delivery, and frontline practices are challenged by the presence of migrant and mobile populations. In response, facilities were creative in how they improvised in order to treat the greater number of patients, while attempting to maintain access and quality. Return migrants have an impact on stock planning, health and risk behavior, size and nature of rural caseloads, and treatment follow up – illustrating the diverse forms of migration that exert demands and shape health delivery and place.

CONCLUSION

The findings of this study support previous research that highlights the importance of engaging with place and migration in South Africa for understanding and strengthening health-care provision in the country (Vearey and Nunez, 2010). The findings of this study show that diverse places present heterogeneous migrant profiles, including internal and cross-border migrants, truck drivers, pregnant women, and contract workers, each presenting various and differing demands on the public-health system. Such heterogeneity includes internal migrants who return to their rural homes during the year – highlighting the importance of internal mobility. The study points to the importance of understanding both the places in which migrants interact, the corresponding patterns of demand on the health-care system, and the health-care system's responses. Various places are sites where things get done, demands are placed, plans are made, exposure to health threats is a daily reality, and there is improvisation and negotiation from both health-care users and providers.

In South Africa, a greater awareness of migration and mobility – both internal and cross-border – must be central to public-health care and local municipality planning and service delivery (Vearey, 2010). As argued by Cummins et al. (2007), Macintyre et al. (1993), and Jones and Moon (1993), research on health and place should not separate context and composition – there is a reciprocal relationship between place and people (including migrants and mobile populations) in South Africa and the wider southern African region. The findings reveal a holistic picture of challenges facing the health-care system in South Africa and support existing research that highlights the importance of engaging with a place-based approach (Todes and Turok, 2018). The findings from the health-care providers interviewed in this study are in line with the views of the International Organization for Migration (IOM, 2013), that levels of insecurity in South Africa are high in general, and particularly

in poorly resourced areas where migrants are concentrated. Moreover, the recurring complaint expressed by health-care providers around the abuse of free treatment and medication (in spite of a lack of evidence) might be the cause of blocked access and providers' attitudes toward cross-border migrants. This was also echoed by Walker and Gilson (2004) as they argue that there are some signs that policy unexpectedly contributes to a decline in health-care providers' moral attitudes toward patients, with the free health-care policy identified as a cause of concern rather than affirming notions of solidarity, social rights, and health-care entitlement. If this is a correct interpretation, then policy framing must adopt a bottom-up approach, including equipping providers with communication and interpersonal skills and strategies to assist their work with migrant and mobile populations, and ensuring that facilities' planning and stocktaking processes take account of the realities of heterogeneous migrant flows, including return migrants. Here there is support for Kearns and Joseph's (1993) and Kearns' (1991) arguments that whether it is in rural areas or an urban space, the unique qualities of places and residents will contribute to the contours of health status and health-care service delivery.

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