

The paradox of free access to maternal health: The twofold narrative of pregnant migrant women in Johannesburg

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Maternal health is a key issue in any health discourse, in any country. Access to healthcare for pregnant women is a concern of governments the world over. However, in South Africa, a binary system separates migrant and non-migrant women, favouring non-migrant women's access to maternal healthcare. The paradox of pregnant migrant women's access to healthcare has therefore become topical among researchers, in a bid to understand the issue, and consequently, influence policy. The present study was designed to explore the concerns of migrant women accessing maternal healthcare in Johannesburg. Through a qualitative design, a non-representative sample of 15 migrant women and healthcare providers were interviewed, and the findings were coded and analysed according to thematic content. The findings show the context in which free access to maternal healthcare has created a paradox within the system. This is especially the case in terms of access, consultation time and the dissemination of drugs for migrant women, and also at an administrative level, where lack of access to and shortages of drugs are now considered a result of abuse, overuse and misuse of free access to healthcare services by migrant women. The punitive approach of denying migrant women access to maternal healthcare creates a binary of contradictions where on the one hand, access is supposedly free to all, while on the other, some are excluded, or receive healthcare only partially.

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The experiences of migrant women in accessing maternal healthcare have become topical in public health, both at the facility level and as a research field. In relation to the increasing numbers and changing trends in migration worldwide, the provision of and access to maternal healthcare of migrant women is highly politicised and controversial.^[1,2] Providing adequate access to healthcare services is therefore a matter of concern for governments, and most commonly for local councils who receive migrants in large volumes, where capacity has not been created to cater for the increasing numbers. Like other middle-income countries, South Africa (SA) receives vast numbers of migrants, the majority headed for Johannesburg. SA is the destination of choice for 58.4% of Southern African Development Community migrants,^[2-5] and Johannesburg is a city of migrants, both internal and international. As Gauteng Province became the economic heartbeat of the country, more people migrated to the province (and particularly Johannesburg) in search of employment opportunities (formal and informal), education and healthcare, among other advantages.

The healthcare system is intended to cater for Johannesburg residents registered through official housing allocations, in both townships and suburbs. Healthcare provision for urban migrants has become a challenge. The system was designed such that each primary healthcare centre could cater for 10 000 people

per year; however, these facilities each now attend to on average 18 114 per year.^[6] This care includes consultations, medicines, casualty departments and emergency services. Inward migration to Johannesburg adds half a million people per year to the city, overloading the healthcare system.^[6] The provision of healthcare in SA follows a rights-based approach, where citizens are able to access the services as and when needed. For internal migrants, healthcare cannot be denied, but for external migrants (from other countries), the system works quite differently. These migrants may be denied healthcare, at the facility level, either by the healthcare providers or by policies that exclude them, or sometimes by the community in which they find themselves, as xenophobic attitudes are fairly prevalent in townships in SA.^[6]

However, the National Health Act No. 61 of 2003 (NHA) made significant changes regarding access to healthcare. The Act made the groundbreaking provisions that pregnant and lactating women, and children below the age of 6 years, are eligible for free treatment in public healthcare facilities, regardless of nationality or residency status.

External migrants face great difficulty in accessing healthcare, and for pregnant women, the situation may be aggravated by a number of circumstances, for instance, a language barrier, non-possession of legal documents or the unavailability of household

or personal finance, among other determinants. The treatment of migrants in SA society has remained poor, and the health system seems to follow similar patterns. The provision of public healthcare to migrants, particularly the disadvantaged, refugees, the undocumented and asylum seekers, remains a challenge, especially at facility level by the frontline healthcare staff popularly known as 'street-level bureaucrats'.^[7] This, like many other challenges of implementation in the healthcare delivery system, enables criticism of a system that on paper calls for a non-discriminatory access to public health. Post-apartheid SA's public healthcare system and health service delivery continues to be affected by its controversial past, including racial and gender discrimination, violence and inequalities.

The context of reproductive health in SA

The SA health system has, since the end of apartheid, made commendable efforts to confront various hurdles, many of which still persist. Racial and sex segregation, the migrant labour system and huge pay disparities all formed part of SA's troubled past, and these affected reproductive health. A number of desirable features of the primary healthcare system, including privacy, are not in place, with a substantial human resource crisis confronting the health sector.^[7]

Before 1994, there were no comprehensive reproductive policies in SA. Women's health services comprised mainly maternal and child healthcare, with an emphasis on contraceptive services directed at restricting population growth.^[8] The greatest proportion of health resources was channelled to the white minority in urban areas.^[9] The public-sector health system was divided, and defined by ecological and racial imbalances, while maternal health facilities struggled with overcrowding, understaffing and lack of privacy, and women frequently encountered access problems.^[10]

In 1995, a Maternal, Child and Women's Health directorate was established within the National Department of Health. Among its objectives was to increase women's access to proper health services, and provide services to women and men that facilitated the attainment of optimal reproductive and sexual health.^[9,11] In 1996, Nelson Mandela passed his first piece of healthcare legislation, the Choice on Termination of Pregnancy Act No. 92 of 1996.

According to the World Health Organization,^[12] owing to the HIV epidemic and the underperformance of the health system, SA in 2012 was one of the few countries worldwide with increased mortality since 1990 for Millennium Development Goals (MDGs) 4 (child survival) and 5 (maternal health).

Maternal mortality statistics before and after 1994 cannot be authentically compared. Prior to 1994, data were typically collected only in urban areas and among women giving birth in maternity homes. This led to substantial underestimates of maternal mortality. Between 2009 and 2016, institutional maternal death ratios decreased from 189 per 100 000 live births to 134 per 100 000.^[13] Nevertheless, the country is still extremely far from meeting the international commitment to cut maternal mortality to 38 deaths for every 100 000 births by 2015, as one of the MDGs. Despite the more recent introduction of the Sustainable Development Goals, SA is still struggling to cut its maternal mortality ratio.^[3]

SA exemplifies a nation that has undergone a protracted and polarised health transition, as evidenced by the persistence of infectious diseases, high maternal and child mortality and the rise in non-communicable diseases.^[14] It should be noted, however, that the country has shown a concerted national and state response to public health challenges through policy and legislative changes. The African National Congress (ANC)'s health plan, published in 1994, was the post-apartheid model for health system change. This was driven by the urge to redress historical inequities by providing essential healthcare to the disadvantaged. Primary healthcare became available for patients without medical aid. Under this policy, the new government achieved several successes. Primary healthcare, delivered through the district health system, was made the cornerstone of health policy. There was a clinic infrastructure programme in which 1 345 clinics were built, and over 200 upgraded, and this improved the availability of and access to healthcare services.^[7] By 2014, SA had 3 182 public clinics, with the most recent edition of *SA Health Review*^[3] putting the number of public clinics at 3 192. Currently there are 5 211 primary healthcare delivery points, of which 3 190 are clinics.

The NHA, passed in 2004, saw the district health system and primary healthcare being defined as provincial responsibilities. The NHA enacted a national health system framework integrating the public and private sectors, and providing equitable healthcare services.^[15] It provided for fulfilling the rights of children in terms of nutrition and basic services, and entrenching the rights of pregnant women and children to free care throughout the public sector, if they are not members of a medical aid scheme. Section 4 of the Act lists the ways in which people (regardless of nationality) can gain access to healthcare services. It notes that pregnant and lactating women and children beneath the age of 6 years are eligible for free treatment in public healthcare facilities. Scholars have, however, argued that although the NHA guarantees access to health for all, migrant women with special health needs face challenges in accessing public healthcare.^[13,16,17] Attention to the maternal health needs of migrant women is still limited in SA. Where migration health policies do exist globally, they operate primarily in isolation at national level, and cover only fragmented snapshots of people's movements.^[18]

Investigation of migration and health frequently compels one to recognise that the two types of migration (international and internal) interact with one another, as well as with other population parameters such as age, sex, fertility, mortality and family structure.^[19] Crush *et al.*^[15] argue that paramount to understanding migration and health is the identification of the complex social challenges faced by different migrant groups in the spaces of vulnerability associated with migration, both internal and cross-border, which are mostly ignored in health planning and governance. There is a need to advocate for healthy migration in Africa. MacPherson and Gushulak^[20] explain that linkages between migration and health are not linear.

Health-system planning in SA does not effectively engage with the health of migrants when they are in urban and peri-urban areas. As a result, internal migrants often return home to the rural areas when they become sick.

Health policy-making in many developing countries has often divided opinions between civil society and government agencies. In this regard, 'health policy-making in the context of migration has generally been viewed either in terms of its "threats" to public health or from a rights-based approach that focuses on health hazards faced by individual migrants and the associated service challenges.'^[21]

Historically, the majority of health matters linked with migration, or taking place as a result of migration, have been managed at the national level in SA. This has been accomplished through either immigration health activities, or exclusion of foreign migrants, or as a factor in other local health programmes.^[17,18,20,22] Attention to the health of migrants in SA is still restricted. Vearey *et al.*^[3] state that the isolation of non-citizen groups has resulted in health becoming conflated 'with the politics of citizenship, in many instances leading to denial of healthcare to non-citizens. Various negative assumptions have been made that unjustifiably relate cross-border migration and internal migration with the spread of diseases, and with healthcare seeking. This in the long run positions migrants as placing a burden on the healthcare system of host countries.^[23] The migrant body has always been associated with disease in both the public mind and academic literature.^[24] Zimmerman *et al.*^[17] argue that 'although often framed as a "threat", human mobility is not inherently risk-laden.' The relationship between migration and health is a complex one.

Methodology

Jeppestown was identified as the study site. Jeppestown is situated on the periphery of the city of Johannesburg in SA, and falls under region F of the City of Johannesburg Metropolitan Municipality. The percentage of migrants (internal and cross-border) in the Jeppestown population is estimated at 47%, and owing to this Jeppestown is migrant dominated. Most of the residents are poor, and depend on public clinics and hospitals.^[25] The area has an 89.3% black African population.^[23] The Johannesburg Population Survey shows that Jeppestown is a migrant-populated city, with internal migrants from all the nine provinces of SA, as well as cross-border migrants from Zimbabwe, the Democratic Republic of Congo, Malawi, Mozambique and Kenya, among other countries. Initially, it was a light industrial area. Jeppestown has many abandoned buildings that have been illegally occupied by residents in the area.

The majority of the research for the present study was conducted at facility level, at the Jeppe Clinic.

This research made use of two sets of semi-structured interviews, focusing on two groups of people. The first targeted health governance actors, including frontline healthcare staff, and facility, clinic and regional managers. This group was selected on the premise that they are responsible for health provision, and for the formulation and implementation of health policies in SA. These included key health governance actors in region F of the City of Johannesburg. Although they formed part of this research project, the views of the second group, migrant healthcare-seeking women, are not discussed in this article. The governance actors were at facility level, or from the Johannesburg health district, region F of the City of Johannesburg. The primary data were collected using

in-depth semi-structured interviews, with the aim of accessing rich, in-depth narrative experiences.^[26]

A non-representative sample of 19 participants (9 healthcare staff and 10 healthcare seekers) were interviewed for the research. The views discussed are those of the healthcare staff. The findings were coded and analysed by means of thematic content. The interviews were all audio-recorded, upon consent being obtained. Audio-recording the interviews was important to ascertain the validity and reliability of the research. Participants had the option to refuse being recorded if they felt uncomfortable, however. All the interviews were conducted in English. Plain language was used, which allowed participants to internalise questions and respond to the demands of each question. Each interview was scheduled to take 30 - 45 minutes. Informed consent to participate was sought and granted. All ethical considerations were observed (University of the Witwatersrand Research Ethics Committee ref. no. H17/09/20).

Results

The setting of this research, considering the politicking around the proposed National Health Insurance, allowed for many different views. Some followed the positions taken by prominent populist politicians, which bordered on prejudice and discrimination. The position of frontline healthcare staff toward rendering healthcare services cannot be understood without examining the politics of SA, especially around immigrants. These positions can be categorised under the following subheadings.

'Migrants are burdensome to the healthcare system'

Frontline healthcare staff seemed to curry the favour of politicians in dispensing their services, despite the health regulations. The mayor of Johannesburg at the time of the study, Herman Mashaba, has often been quoted in the media saying that migrants in Johannesburg are not welcome – in particular, undocumented migrants (EWN, 2019). Frontline healthcare staff adopted this perspective to argue that they were unable to predict the number of expected migrants in any given year, and therefore could not budget appropriately to dispense healthcare services. In one of the interviews, a frontline healthcare staff member said:

'... Much as we would want to plan for them, we can't plan for them. Remember we have also the financial constraints as a country' (Gugulethu).

This statement is not without context. The healthcare budget for the country, distributed to national and provincial government, has allowed for some healthcare services to be dispensed free of charge. Provision has been made for a certain number of people per province, and most importantly, per facility. This assumption that the number of migrants per unit is unknown, and therefore strains the already limited resources, may not necessarily be true, and may have been used as justification to draft unconstitutional facility practices that discriminate against some users. Apart from this statement being highly politicised, it points to deeper incompetence in the healthcare system, in that the system fails to make projections about the number of pregnancies per facility per year, and budget for the associated services.

'Migrants cannot be trusted, they are cheating the system'

Healthcare staff's attitude towards migrants is of major concern, considering the services they render to, in this case, external migrants. There is a deep suspicion that migrants have an agenda to destabilise the health system, by misrepresenting their health needs. In this case, there is a stereotype upheld by some healthcare staff that migrants move from facility to facility asking for assistance and that in the end, what they do with the medication they receive is unknown. In another interview, a healthcare staff member said:

'People would go and get medication in facility A, the following day go to facility B. One week a person would have travelled [to] 5 clinics if not 10, because in the morning she goes to this one and in the afternoon another one just collecting medication and we don't know what this medication is used for. We don't know whether it's used as part of "concoction" of drugs that arrive in the country. We don't know whether these women are opening mini- pharmacies and selling these drugs' (Thembi).

This is a deliberate smear campaign, it seems, by this healthcare staff member, to suggest that, firstly, the non-SA nationals are criminals, stealing from the healthcare system, and secondly, that these foreigners have no legitimate healthcare concerns. The second implication is more concerning than the first, considering that it is maternal healthcare being discussed. It seems implausible that women would fake pregnancies in order to receive antenatal care at facilities. On the other hand, what is plausible is that these migrant women move from facility to facility because they do not receive any assistance. They are likely to have to visit multiple facilities before being given the help they need, but also as a result of the nature of their residence in the city. Most migrant women only have temporary accommodation in any given area, and therefore, once their means can no longer support them, they move to a different area. Sometimes, this is very far from the facility they initially contacted. The temporary nature of their domicile makes it possible to move from one place to another without notifying the relevant service providers.

'Migrant women are wasteful, and therefore abuse our systems'

Healthcare providers complained that migrant women (both internal and external) are doing what they term 'double consultations', visiting different facilities in one day, thus abusing and wasting resources. There is an assumption by the healthcare staff that migrant women are not to be trusted, and that they are creating chaos in the systematic distribution of resources. For instance, in an interview, Monny suggested that the migrants are ungrateful: they receive free services, and they abuse the system by having multiple consultations. She said:

'The fact that healthcare at the district level is a free service, it has a huge negative implication, because people are now abusing the system' (Monny).

This seems to carry a narrative that supports demonising migrants as reason to disenfranchise them.

The above findings seem to suggest that there is something inherently amiss with being a migrant. There are, however, systematic procedures that need to be followed for someone to receive healthcare, especially when carrying a pregnancy to term. This is based on the fact that a pregnancy is not an emergency activated on delivery; it is a process that takes 40 weeks. Pregnant women are therefore required to register their pregnancy any time before 20 weeks' gestation with the facility closest to them. Once this is achieved, the public primary healthcare centre will deliver antenatal care until the birth, and further care after the birth, although the delivery is done at the hospital level. Women, migrants or otherwise, should abide by this policy so that the services can be distributed appropriately. Migrant women, however, reportedly do not adhere to this, only showing up at critical stages of their needed care, which in turn causes unnecessary pressure on the centre and the staff. An interview with a nursing sister revealed that:

'Late booking that is the first one and I think one of the challenges. Booking after 12 weeks, at 3 months. Ideally, we want them to book before 12 weeks or at least before 20 weeks but you find that others come just before the month before they deliver. I don't know. You know what (pauses) I wouldn't know. But from what we hear from patients they will say its attitude. I don't necessarily know what the problems are. Beside them saying its staff attitudes that prevent them from coming. I would turn it around and say it's their attitude also' (Lebohang).

The misunderstanding between the healthcare providers and the migrant women seeking services seems to stem from a policy point of view and ideological positioning. For the nursing staff, it is imperative to register a pregnant woman early in their pregnancy, so that they can monitor the pregnancy for any abnormalities, and also offer affiliated services such as HIV counselling and testing. This is done to ensure prevention of mother-to-child transmission if the mother is HIV-positive. Unlike the nursing staff, who are procedure-oriented, the service users are more concerned about receiving the service, as a right, but ignore the procedures. This becomes a contestation of power, and whoever has more at the time seems to win. In the event that the nurse is correct to refuse the service based on procedure, the broader narrative will still always favour the pregnant woman, thus jeopardising both the nurse's career and the facility in question.

In addition to this challenge, there is the life-threatening problem of the system's inability to track the (non-)complications of each individual pregnancy. Maternity care is a caring service offered to highly emotionally vulnerable women. It is therefore imperative for the healthcare system to be able to identify potential problems from the beginning. Late presentations complicate the provision of services, considering the risk to be undertaken and also the professional expertise required. In interviewing one healthcare provider, she concurred that:

'Unbooked cases. They are giving us such a challenge. We can't pick up problems on time. They will come when they are due for delivery. Sometimes the person is having hypertension, sometimes it's a previous caesar and we can't just deliver you like that. At the clinics we have something that we call in

midwifery “trial of a scar”, meaning when you had a caesar with your first baby, during your second pregnancy in hospital they can try and put you to see if you can deliver normally with your second baby. But in clinics, it’s a risk that we cannot take. Once a woman had a previous caesar, whether it’s once or twice, we refer them to the hospital. So sometimes a person delivers with a caesarean somewhere wherever, and then with the second baby they feel that they want to deliver their child normally. They are forgetting that it’s not because you wanted or doctors just needed to do the procedure. There is an indication why we do caesar. So, they don’t have that information’ (Gugulethu).

Discussion

Access to healthcare for undocumented migrant children and pregnant women brings about a confrontation between human rights and professional values, and the political and institutional regulations that limit services. The concerns that the healthcare staff have are not without foundation. Research on maternal health for migrants across the health system seems to suggest that health risks are posed by offering antenatal care services to any woman whose history is unknown.

For instance, Almeida *et al.*^[27] argue that some migrant populations appear to have a higher incidence of diseases that can affect pregnancy and the postpartum period, particularly anaemia. This study also reported that the rate of congenital malformations is significantly higher in some migrant groups. An Italian study supported this finding, showing illegal immigrants to be at higher risk of teenage delivery, complications of pregnancy, miscarriages and induced abortions.^[21] Other studies have shown that higher rates of anaemia, excessive bleeding and fetal distress occur among the undocumented population.^[28,29] A study conducted in France indicated that the risk of postpartum maternal death was twice as high for foreign women (from sub-Saharan Africa, Asia, and North and South America). The risk of dying from hypertensive disorder or infection was four times higher for immigrant women. The quality of care received by women who died was often less than optimal in immigrants (9.1%) compared with French women (28.8%), and therefore some of these deaths may have been preventable (23.5% v. 12.7%).^[27]

Beyond the medical risks associated with pregnancy, migrants may receive inferior care as a result of inappropriate pregnancy strategies, inadequate medical treatment and miscommunication. Poor communication between women and caregivers can result in inadequate care because of undiagnosed symptoms or poor compliance with treatments. Migrant women in previous studies mentioned above, often reported delays in receiving information on diagnosis and treatment. SA has similar problems in this respect. There are 11 official languages, and many are localised to a particular province. This presents an everyday challenge, where officials have an added responsibility to learn to communicate with migrant women with low literacy levels, who are also monolingual in another language. The case of foreign migrants exacerbates this situation, especially if they also have low literacy levels and are monolingual.

A study in Germany^[30] reported that access to healthcare services for migrants was similar to that for local residents for the majority of migrant women during pregnancy, suggesting that

observed differences in outcomes were related to the quality and content of the antenatal care. Health outcomes and indicators tend to be poorer when legal documentation has not been obtained.

The concerns of migrants seeking help should not be dismissed, regardless of the absence of a fixed abode. Female migrants have always needed greater social security in host cities, because of the disadvantages they face. Beyond the fact that the nature of their employment is often precarious, their wages are usually at subsistence level, below a living wage. For instance, a report by the International Organization for Migration on migrant female remittances suggests that female migrants contribute very little family income in comparison with men. The report cites poor working conditions and job quality as reasons, since the majority of these women work in temporary, part-time, low-skilled jobs.^[12] Their ability to pay user fees for healthcare is therefore greatly compromised.

Conclusion

The provision of health services to migrant women remains a challenge in SA, as elsewhere in the world. The policy challenges confronting health workers remain a significant impediment to diligent health staff in dispensing their services. However, it should be noted that following procedure is mostly done for the good of the pregnant women, in order not to exacerbate the risks already confronting them in pregnancy. The health risks to be considered are significant to mother and child health and cannot be negated, despite the provision of healthcare being a fundamental human right. There is also a politics of migration that has been adopted by the ‘street-level bureaucrats’ in healthcare facilities, according to which migrants are blamed for all problems when it comes to public health-seeking. This has led to the labelling of non-nationals as criminals and threats to jobs and health, creating a series of extra-legal and often unconstitutional practices around control, denial of healthcare services and the blame game. There is a need for frank discussions on maternal health injustices with regard to migrant women’s needs. Migration remains a central determinant of health, and the situation requires appropriate policy response and a programme of action. The paradox of free access to maternal health challenges the SA public health system to develop migration-friendly responses that will address migrant women’s needs in seeking public maternal healthcare.

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