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Review Article

High Utilisation and Subtle Barriers: Migrant Public Healthcare Access in Yeoville Bellevue, a South African Urban Community

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Abstract

Introduction: The Yeoville Bellevue community is a major destination for both international and internal migrants due to its proximity to inner-city Johannesburg, which is perceived to offer many employment opportunities. Consequently, the suburb is known as the migrant community. This phenomenon strains resources, including healthcare, resulting in tension amongst residents. This study investigated the lived experiences of migrants accessing public healthcare services in Yeoville clinic.

Methods: This was a qualitative study with phenomenological approach. Fifteen international migrants aged 18 years and older were purposively invited to participate in the study. Semi-structured interviews were conducted and analyzed thematically using Atlas.ti.

Results: While the migrants reported high utilisation and minimal overt barriers, structural challenges appeared to be normalized rather than recognized as barriers, reflecting adaptive responses to constrained healthcare environments. Subtle covert barriers such as long waiting times, language differences, and limited cultural sensitivity were identified.

Conclusion: Yeoville clinic, the sole public healthcare facility in the area, seems to be broadly inclusive. However, operational and policy gaps exist. Our findings suggest the need for targeted investment in staff training on migration-friendly care, interpreter services, and inclusive patient registration systems.

Keywords: Migration, Healthcare access, Urban health systems, Healthcare barriers

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Introduction

Yeoville and its neighbouring suburb, Bellevue, are Johannesburg suburbs in Gauteng province, South Africa. Yeoville's total population is 38 965, with 48% South Africans and 52% immigrants.[1] Geographically, Bellevue is small and less well-known, and it is often mistakenly considered part of Yeoville because the demarcations between the two suburbs are unclear. In 1890, about four years after the discovery of gold in Johannesburg, Thomas Yeo Sherwell, a British migrant, proclaimed Yeoville a suburb.[2] The discovery of gold attracted a large workforce, especially men from across Africa, who settled in Yeoville and the surrounding areas. Although conditions have evolved, immigration to Yeoville and Bellevue has persisted due to their proximity to commercially vibrant centers such as inner-city Johannesburg and numerous nearby employment opportunities. This phenomenon is straining resources, including healthcare, resulting in tension among residents.

Some scholars concur that negative perceptions associating migration, particularly international migration, with the spread of infectious diseases exist in South Africa.[3–5] It is against this background that the objective of this research was to investigate the challenges faced by migrants in accessing public healthcare in the Yeoville Bellevue community.

In South Africa, migration is both historically rooted and currently relevant, with migration trends closely tied to labour, politics, and socio-economic factors.[6] Public perceptions of migration remain polarized and, at times, inflamed by media narratives. Misconceptions and stereotypes continue to fuel anti-migrant sentiments, which often manifest in harmful rhetoric and, occasionally, violence.[6]

Governments have an obligation and responsibility to provide the conditions necessary for people to enjoy their health rights.[7] The three duties and obligations under international law are to respect, protect, and fulfill human rights.[8]

Migration and Immigration Policy in South Africa

The 1996 South African Constitution is the supreme law that healthcare providers and Civil Society Organisations (CSOs) look to in evaluating access to healthcare for refugees, asylum seekers, and immigrants.[9]

Under the Constitution, there are three main laws

and immigration regulations that guide South Africa on questions relating to refugees' and migrants' access to health and emergency care. These are the National Health Act of 1998, the Refugee Act of 2008, and the Immigration Act 13 of 2002. This is illustrated in Figure 1.

Section 27 (1) of the constitution of the Republic of South Africa guarantees everyone the right to access health care services. It states that no one may be refused emergency medical treatment. Section 27 (2) imposes on the state a duty to take reasonable measures within its available resources to achieve the progressive realization of this right.[10]

The National Health Act provides some of the most comprehensive language with respect to administering care to South African residents. The National Health Act 61 of 2003, Chapter 1 (2)(c), commits the government to: protecting, respecting, promoting and fulfilling the rights of: (i) the people of South Africa to progressive realization of the constitutional right of access to health care services. (iv) vulnerable groups such as women, children, older persons, and persons with disabilities.[10]

Populations distinctly missing from the vulnerable groups list include asylum seekers, refugees, and indigent immigrants. Arguments that immigrants, especially the undocumented ones, should be considered vulnerable because of their unclear legal standing extend to contexts such as health access.[11] The gap associated with healthcare access, place medical providers such as doctors and nurses, in difficult situations when evaluating patients' needs and the levels of care that patients can afford.[12] The National Health Act has language in the statute that suggests an aspiration to care for all South Africans.[12]

The Refugees Act 130 of 1998 states that a refugee is entitled to the same basic health services and primary education as South Africans.[12] The Refugees Act, consistent with the National Health Act, reinforces the notion that refugees are also entitled to basic health services; however, it does not explicitly refer to asylum seekers or other foreign nationals. The National Health Act and the Refugees Act are both undermined by the Immigration Act 13 of 2002. In the Immigration Act, medical care providers are to ascertain the legal status of patients before administering care.[12] This clearly contradicts South African doctors' Hippocratic Oath, in which doctors swear to uphold the health of patients and the health of their communities.[12]

The right to health requires that healthcare systems be available, accessible, acceptable, and of good quality for all, regardless of legal or migration status. While South Africa's constitution and international commitments uphold this right, recent policy developments, such as the 2023 National Health Insurance (NHI) Act and the 2024 White Paper on Citizenship, Immigration, and Refugee Protection, mark a shift toward institutionalized exclusion. Discriminatory practices that were once informal are increasingly codified in law, aligning healthcare policy with a broader securitization agenda and undermining progress toward Universal Health Coverage (UHC).[13]

Medical Xenophobia

Xenophobic attitudes and actions are all-pervasive in South Africa in civil society and the state.[14] Medical xenophobia refers to the negative attitudes and practices of health professionals and employees towards migrants and refugees based purely on their identity as non-South African.[14] Medical xenophobia in South Africa is not merely episodic but structurally embedded within public health institutions, often manifesting through documentation requirements, denial of care, and negative provider attitudes. Such practices undermine equitable access to healthcare and contradict constitutional and human rights commitments.[14]

The consequences of medical xenophobia are significant. Migrants may delay or avoid seeking healthcare due to fear of discrimination, harassment, or deportation, leading to worsening health outcomes. These dynamics do not only undermine individual well-being but also pose broader public health risks, particularly in relation to communicable diseases and maternal health.[15] Some migrants may demonstrate remarkable resilience through practices such as adaptive preference or normalized adversity.[16] Adaptive preference describe the process by which individuals adjust their expectations and aspirations in response to persistent deprivation or limited opportunities. Closely related to adaptive preference is the concept of normalized adversity, where repeated exposure to systemic challenges

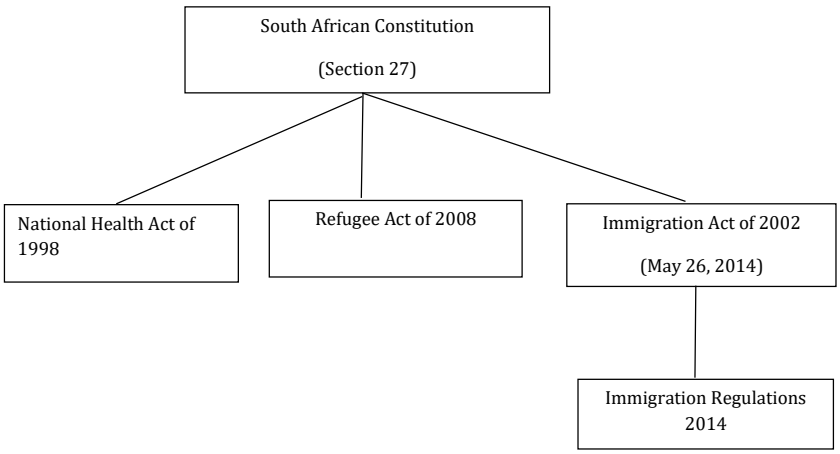

Figure 1. Primary South African laws on access to healthcare

leads individuals to internalize these constraints as routine features of everyday life rather than as inequities requiring redress.[16]

Methods

This study employed qualitative phenomenological approach. Semi-structured interviews and participant observation were used to explore migrants' subjective experiences of healthcare access. Fifteen international migrants aged 18 years and older who live temporarily or permanently in Yeoville Bellevue community and access or accessed public healthcare at Yeoville clinic in the past 12 months were purposively sampled and interviewed.

A non-probability sampling strategy was implemented, with purposive sampling utilized to choose the sample of respondents who met the eligibility criteria for this study. A sampling frame was drawn up from two clusters that are frequently patronized by migrants, these are; Yeoville Recreational Center (YRC) and Rockey Street.

Once the two clusters were identified, key informant interviews commenced, ranging from 20 minutes to 40 minutes, depending on the key informant. This study identified six key informants: a member of the African Diaspora Forum (ADF), an organisation of African international migrants, two patrons, a ward councilor stationed at YRC and two Rockey street shop owners. The six key informants were engaged primarily to facilitate access to the study population and assist in identifying eligible participants. These individuals provided contextual insights into the community and migration dynamics; however, their contributions were not included in the thematic analysis, which focused exclusively on the semi-structured interviews conducted with the 15 migrant participants.

The final sample size (n = 15) was determined by the principle of data saturation. Data saturation is achieved when no additional themes or insights emerge from the data collection, and all conceptual categories have been explored, identified, and completed.[17] This sample is consistent with exploratory studies, which often benefit from smaller, focused samples that facilitate in-depth exploration of participants' lived experiences. A qualitative study examining the experiences of caregivers for individuals with dementia might involve in-depth interviews with 10–15 participants, as these numbers can provide sufficient depth to identify key themes.[18]

Seven participants were selected at YRC and another eight along Rockey Street using purposive sampling. While this method allowed for the adequate selection of participants, snowball sampling was incorporated for participants who were more difficult to access.

Semi-structured interviews were conducted, aided by an interview guide, once participants agreed to be interviewed. The interview guide comprised mainly open-ended questions, which allowed the researcher to identify, perceive, engage, and probe migrants' subjective experiences of healthcare access. All interviews were audio-recorded and transcribed, except for one participant who disapproved of being voice-recorded but consented to being interviewed; thus, the participant's responses were noted down and used in the study. The researcher also took notes and observed participants during interviews.

All interviews were conducted in English. Participants were required to have at least basic conversational proficiency in English to participate in the study. In instances where participants had limited fluency, clarifications were made through probing, paraphrasing, and the use of simple language to ensure accurate understanding of responses.

A private room in Yeoville library was used as the venue for interviews; permission was granted by the librarian (Appendix A). The library is situated along Rockey/Raleigh Street, in the middle of the two recruitment clusters (YRC and Rockey Street). Most participants preferred the library for interviews; however, some chose to be interviewed at the recruitment clusters.

Ethical Considerations

Ethical approval for the study was granted by the Stellenbosch University Research Ethics Committee (Ethics Reference Number: 0781) (Appendix B). All participants provided informed consent before participation. Confidentiality and anonymity were ensured through secure data storage and removal of identifying information.

Results and Discussion

The findings of this study were derived from observation and semi-structured interviews conducted with fifteen participants (n = 15). The demographic information of participants is presented in Table 1.

Out of the fifteen participants, two were Nigerians, five Zimbabweans, one Mozambican, five Congolese, one Ethiopian and one Bangladesh. Other demographic details of the respondents are presented in Table 1.

Key findings of the study are presented, and their

Table 1. Participants demographic information

Participant	Sex	Age	Homecountry	Number Of Years As Yeoville/Bellevue Resident
M1	Male	42	Nigeria	11
M2	Male	35	Nigeria	4
M3	Female	33	Zimbabwe	15
M4	Female	36	Zimbabwe	6
M5	Male	23	Zimbabwe	3
M6	Female	30	Zimbabwe	2
M7	Male	62	Mozambique	20
M8	Female	37	DRC	11
M9	Male	45	DRC	11
M10	Male	35	DRC	13
M11	Male	30	DRC	16
M12	Male	38	Zimbabwe	11
M13	Male	56	DRC	16
M14	Female	35	Ethiopia	10
M15	Female	26	Bangladesh	5

implications are considered. Despite some prevailing negative assumptions linking migration and health, Yeoville Bellevue, represents a distinctive urban context. The study found high utilisation of public healthcare services by international migrants, primarily due to financial constraints and perceptions of thoroughness and quality of care.

Most participants reported minimal challenges in accessing public healthcare and indicated that they had not experienced discrimination at the Yeoville clinic. These findings are in contrast with some studies that show understanding of population mobility remains limited within the South African health sector, and migration narratives are always hostile.[6,19] Yeoville's population is 38 965 and has an almost equal number of locals and international migrants, 48% South Africans and 52% immigrants, and is widely recognized as a migrant community.[1] While this phenomenon strains resources, including healthcare services, it also appears to limit the overt practice of medical xenophobia, which tends to manifest more strongly in healthcare settings located in areas predominantly populated by South African citizens. An overview of the three key findings is presented in detail below.

Theme 1: Usage of public healthcare by migrants

The first part of the interview asked two questions which sought to determine what were migrants' first point of healthcare access when they or household members fell ill or got injured. Participants were asked where they usually seek medical attention when sick. The majority of participants (n = 13) said they sought medical attention at a public facility, Yeoville clinic. While (n = 2) said they had used Yeoville clinic before, but they only use public facilities when referred from private facilities or for minor ailments. This is consistent with the 71.2% of South African households reportedly using public clinics, hospitals or other public institutions as their first port of call in accessing healthcare.[20]

The high utilisation of public healthcare services among migrants reflects not only affordability and accessibility. It also indicates migrants' structural positioning within the health system, where public healthcare becomes the default and often only viable option. This reliance on public facility highlights constrained healthcare choices rather than genuine preference, suggesting a form of conditional inclusion within the system. On the other hand, the behaviour of few participants indicates how migrants actively navigate between public and private sectors. They make pragmatic decisions within financial and structural constraints.

The second question sought to determine whether respondents were aware of the services offered at their public healthcare facility (Yeoville Clinic) in the community. All participants, (n = 15) indicated that they were aware of the healthcare services and health campaigns in the community by Yeoville clinic. HIV testing, and immunisation drives were the two campaigns most known to participants. Taken together, these findings seem to indicate high utilisation of public healthcare. When probed on why they used public healthcare, participants identified the following reasons: (a) empathy and quality of care, (b) financial implications, and (c) thoroughness.

Category 1: Empathy and quality of care

Amongst the 13 participants who said public healthcare was their first point of access, some expressed empathy and quality of healthcare at public healthcare facility as the main influence of using Yeoville clinic. Participant M4 stated, "*at the clinic, unlike these private surgeries and pharmacies, the nurses are friendly and they understand your illness far much better*". These findings contradicted the prevailing perceptions of private and public hospitals in South Africa, which associated public hospitals with negative unsafe feelings, abusive staff attitudes, neglect, and uncaringness.[21]

The prominence of empathy and perceived quality of care as drivers of public healthcare utilisation challenges dominant negative narratives that characterize South African public health facilities. Participants' positive accounts, particularly the emphasis on being "understood" and treated with friendliness, suggest that interpersonal dimensions of care play a critical role in shaping healthcare preferences among migrants. In this context, relational aspects of care, such as respect, and attentiveness may be valued as highly as, or even more than, technical efficiency.

Category 2: Financial implication

Financial implications ranked second on the list of factors influencing migrants to utilize public health facilities, with four (n = 4) saying medical attention at public facilities is free. As participant M8 remarked, *"at the clinic we don't pay, even if at times we are asked to pay its far more reasonable than in a private hospital and the outcomes are better than in private. So personally, even if I can afford private, I'll go for public"*. This differs from the findings that public service users are rendered 'choiceless' due to affordability barriers to private services.[21]

The role of financial considerations in shaping healthcare utilisation among migrants shows the centrality of economic barrier in structuring access to care. While participants emphasized the affordability or perceived "free" nature of public healthcare services, this preference should not be interpreted purely as a cost-saving strategy. It indicates the broader socio-economic positioning of migrants, many of whom navigate precarious livelihoods and limited access to stable income, making cost a critical factor in healthcare decision making.

Category 3: Thoroughness

Lastly, two of the participants who expressed thoroughness at Yeoville clinic as compared to private facilities. Participant M6 commented, *"at the clinic they test you for everything, they do it properly while most private facilities engage in short cuts"*.

The perception of greater thoroughness in public

healthcare, as expressed by some participants, offers an important counter narrative to dominant assumptions about the superiority of private healthcare services. The view that "they test you for everything" suggests that public facilities are perceived as more comprehensive and methodical in their approach to diagnosis and treatment. This may reflect longer consultation processes, broader routine testing protocols, or a clinical culture oriented toward exhaustive assessment.

Theme 2: Accessibility of Yeoville clinic to migrants

In the last part of the interview, two related questions were posed to participants to determine how easy or difficult it is for migrants to access Yeoville clinic, the only public health facility in the community. Firstly, participants were asked how easy it is to access public healthcare services from the Yeoville clinic. Most participants, (n = 14), said it was easy. Secondly, participants were asked whether they had ever been denied treatment or support at Yeoville clinic. All participants (n = 15), said they had never been denied treatment or support. Participant M5 stated, "*At the clinic, they don't ask you many questions, they just treat you, and you go*". Both these results differ from findings that Johannesburg inner-city non-citizens are essentially unable to access treatment in the public sector, as some facilities insist on the presentation of South African identity document before treatment can commence.[22]

The inner-city includes areas like, Yeoville, Hillbrow, and Berea; some of these areas are part of Yeoville clinic catchment area. Further, these findings seem to reject the motivation of this study which assumed that migrants faced overt challenges when accessing public healthcare services at Yeoville clinic.

These findings challenge the dominant narrative that medical xenophobia is uniformly pervasive. There is variation and context specific experiences, showing that migrants may encounter both inclusion and exclusion within the same health system.

The demographic composition of an area may function as a protective factor, reshaping everyday service delivery practices in ways that are more accommodating to migrant populations.

With a population of 74 131 and migrants constituting 38% of residents,[2,23] Hillbrow has a similar population composition to Yeoville. Hillbrow, however, might not have a protective factor as it is served by a Community Health Center (CHC) compared to Yeoville primary health clinic. CHCs operate as referral centers and serve a population of up to 3 times higher than primary health clinics.[24]

This may indicate that migrant-majority urban settings may function as "zones of relative inclusion" within some otherwise exclusionary health systems.

Theme 3: A complex picture: blurred line between accessibility and denial of healthcare

The interview concluded by asking each respondent how they think healthcare can be improved for migrants, a few participants (n = 4) said the service was satisfactory. Most participants (n = 11), raised factors that can be deemed as barriers to accessing public healthcare and should be reviewed to improve services to migrants; these include language, culture, lack of adequate resources, and slowness of service delivery. On the contrary, ten (n = 10) participants who raised these factors neither viewed them as challenges hindering access to healthcare nor as a subtle form of healthcare denial; they still maintained that Yeoville clinic was easily accessible despite these barriers. When probed further, participant M14 said; *"No, these are just suggestions to improve the service we get at the clinic, it doesn't mean that with them we cannot access service. After all, they also affect some South Africans as well."*

The assertion by participant M14 can be interpreted through the adaptive preferences concept. Adaptive preferences describe how individuals in constrained environments recalibrate their expectations and perceptions of well-being, often accepting suboptimal conditions as satisfactory.[16]

In this study, migrants' characterisation of lack of adequate resources, slowness of service delivery, long waiting times, language and culture differences as "suggestions" rather than barriers reflects a process of adaptation to systemic constraints.

This perspective suggests that medical xenophobia should be understood as a continuum of practices, ranging from overt denial of care to more subtle and normalized forms of exclusion embedded in everyday healthcare delivery.

Category 1: Language

Language was the second most identified factor for improving healthcare services. Participant M11 stated, *"As a basic English speaker, sometimes it's difficult to communicate with nurses, and we end up using gestures and signs to communicate. Imagine someone who does not know English, but the staff there understand and are good"*. Inability to communicate with patients in languages they understand is a serious hindrance in the provision of adequate care, especially evident in the mental health support, which remains one of the biggest challenges.[25] Participant M13 also expressed a similar sentiment: *"They (clinic) used to have a translator long back, but now they don't, maybe it's because now some of the staff members are migrants. I think it's better if they bring back the translator"*.

This can be interpreted through the lens of normalized adversity. Normalized adversity is when persistent exposure to structural inefficiencies leads individuals to perceive them as routine features of the system rather than as inequities requiring redress.[16] Within this framework, migrants' positive evaluation of Yeoville clinic does not nullify the presence of barriers; rather, it highlights how these barriers are socially and cognitively absorbed into everyday expectations of public healthcare.

Category 2: Resources

Participants M1 and M15 suggested stocking up the clinic with all the required medication at all times. Few participants mentioned resources as critical to efficiency.

Participant M15 commented; *"I was involved in an accident only to be given pain killers and panado as the clinic did not have the right medication to treat me"*. This is consistent with the perception that public healthcare facilities in South Africa are associated with large workloads, poor facility maintenance, and shortages of equipment and supplies.[21]

A small proportion of participants reported limited use of the Yeoville clinic, primarily for referrals or minor ailments. This reflects more than individual preference; it points to a form of selective healthcare utilisation shaped by perceptions of risk, quality, and appropriateness of care within a stratified health system. Participants who initially seek care in private facilities may associate private healthcare with efficiency or higher quality of care, particularly for more serious or sensitive conditions. Public healthcare, in this context, becomes a supplementary or fallback option, accessed only when costs become prohibitive or when referrals are required.

Category 3: Culture

Participant M7, commented, *"if only male nurses can be allocated for private ailments, such as Sexually Transmitted Diseases, being checked by females is against my culture"*. There are essential problems of clinical practice across cultures. Illness can frighten migrants; fear is sharper in an unfamiliar place that is linguistically and culturally alien.[26] Only one participant raised culture as a challenge. This may be attributed to the fact that South Africa attracts mostly regional migrants from neighbouring countries such as Zimbabwe, Mozambique, Malawi, and Lesotho, whose cultures are similar.[6] South Africa also receives migrants from countries farther afield; however, the actual numbers remain proportionally smaller compared to regional migrants.[6]

Category 4: Quick service delivery

The majority of participants (n = 8) suggested that speeding up the treatment of patients could be an effective way of improving service. Participant M8 commented, *"People queue as early as 0330Hrs waiting for the clinic to open at 0800Hrs, and after lunch hour, nurses don't attend to anyone, so the clinic closes before everyone is attended. Nurses are slow and worse weekends it's closed"*. Participant M10 agreed with this; *"If they can come up with a better method of controlling queues, sometimes you stand in the wrong queue for a long time, and nurses should take turns when going for breaks"*. This is consistent with findings that slowness of service delivery is a subtle barrier to accessing public healthcare.[27] The "ease of access", therefore, should be interpreted not as the absence of barriers, but as the ability of patients to successfully navigate and endure them.

Conclusion

Migrants in Yeoville Bellevue generally experience meaningful access to public healthcare services in Yeoville clinic. The findings of this study appear to diverge from dominant regional narratives of medical xenophobia. While some studies document widespread discrimination and exclusion of migrants in public healthcare facilities, participants in Yeoville reported largely positive experiences and no outright denial of care.

This divergence, however, seems to reflect a context-specific mitigation of overt exclusion within a high-density migrant community. At the same time, the persistence of subtle barriers, such as long waiting times, resource constraints, language and culture differences, suggests that exclusion may operate in more indirect and normalized forms.

There is a need for staff capacity building that includes structured training in migration aware healthcare, organisations such as Section27 provide these trainings for free. Also trainings in cultural competency and multilingual communication, alongside ethics reinforcement and administrative reforms. These interventions must be institutionalized through continuous mentorship and accountability mechanisms to effectively address subtle and overt forms of medical xenophobia.

Study limitations

This study has limitations that should be considered when interpreting the findings. The transferability of the results is limited due to the study's small, purposively selected sample and its focus on a single urban primary healthcare facility in Yeoville Bellevue. While the findings provide rich, context-specific insights into migrant experiences, they may not be generalizable to other settings with different demographic, institutional, or policy dynamics. However, the study aims for analytical rather than statistical generalisation, offering insights that may apply to similar migrant-dense urban contexts.

Participants were asked to reflect on sensitive issues such as discrimination, access to care, and interactions with healthcare providers. This might have resulted in social desirability bias as some participants may have underreported negative experiences or overemphasized positive encounters due to fear of repercussions, gratitude bias, or perceived power imbalances.

The study included only participants with basic English proficiency, which may have excluded more linguistically marginalized migrants. This could have resulted in the underrepresentation of individuals who may face greater barriers to healthcare access, thereby skewing findings toward more positive experiences.

The study relied on the Census 2011 statistics for the population composition of Yeoville. While Census 2022 results were released in October 2023, detailed small area data (sub-place/ward level) for specific suburbs like Yeoville are often rolled out in subsequent phases and it was not yet available at the time of submitting this manuscript.

Authors' Contribution

Conceptualization: Zibusiso Msimanga, Burt Davis
Data Curation: Zibusiso Msimanga
Formal Analysis: Burt Davis, Zibusiso Msimanga
Investigation: Zibusiso Msimanga
Methodology: Zibusiso Msimanga, Burt Davis
Project Administration: Zibusiso Msimanga

Resources: Zibusiso Msimanga, Burt Davis
Software: Zibusiso Msimanga
Supervision: Burt Davis
Validation: Burt Davis
Visualization: Burt Davis
Writing–Original Draft: Zibusiso Msimanga
Writing–Review & Editing: Burt Davis

Competing Interests

The authors declare no conflicts of interest.

Ethical Approval

Ethical approval for the study was granted by the Stellenbosch University Research Ethics Committee (Ethics Reference Number: 0781). Procedures performed in this study were in accordance with the ethical standards of the institutional and national committee and with the 1964 Helsinki Declaration amendments or comparable ethical standards.

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