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ACCESS TO HEALTH CARE AMONG SOMALI FORCED MIGRANTS IN JOHANNESBURG

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DECLARATION

I declare that this research report is my own unaided work. It is submitted in partial fulfillment for the degree of Master of Arts in Forced Migration Studies at the University of the Witwatersrand. It has not been submitted before for any other degree in any other university.

REBECCA PURSELL 25 October 2005

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ACRONYMS

CASE	Community Agency for Social Enquiry
DHS	District Health System
FGM	Female Genital Mutilation
ID	Identity Document
IDP	Internally Displaced People
IOM	International Organisation of Migration
NGO	Non-Governmental Organisation
JRS	Jesuit Refugee Services
PHC	Primary Health Care
UJP	Urban Johannesburg Project
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

1. INTRODUCTION

Across the world, high levels of poverty, conflict and instability have created the conditions for the mass migration of people out of home countries in search of refuge and stability elsewhere. This migration of people has taken place differently in different parts of the world. In some countries, people have moved in search of opportunities for a better livelihood. In others, people have moved to escape conflict. Irrespective of the motivation, the movement of people poses great public resources challenges.

In the world today, the African continent is the site of some of the most serious contexts of deprivation and conflicts giving rise to mass migrations. Migrants seeking to escape uncertainty and political instability are moving to developed countries in Europe and North America in search of protection. However, many are also moving to other countries in Africa. Worryingly, most of the African countries now receiving large migrant flows are also countries with inadequate resources to meet the needs of their own population. While recognizing the vulnerability refugees' face, many of these countries may be constrained in their ability to respond adequately to the unique needs of forced migrants. This is a particularly grave issue in the South African context.

Since the end of Apartheid, South Africa has received an increasing proportion of the forced migrant flow originating in the conflict states of Africa. This has been attributed to perceptions that South Africa offers many economic opportunities and is a new and evolving democratic society.[1] At the same time, the new democratic government is faced with trying to redress the imbalances of Apartheid, meaning that available public resources are already stretched to capacity to address a society-wide access crisis. This presents a context unlike that in much more resourced and already fairly equitable European or North American countries where forced migrants are settled in urban areas.

Health status and access to adequate health care are two major areas of vulnerability that refugees face. Maintaining health is a challenge because of the undesirable conditions in which many forced migrants live and the health risks commonly associated with the movement of people. Because of this there is good motivation for refugees to access local health care services. In South Africa Section 27 of The Refugees Act 130 of 1998 guarantees refugees the right to the same basic health services available to citizens.

[1] Groot, F (2004) Challenges of the UNHCR's programme for urban refugees in South Africa in Landau, L(2004) Forced Migrants in the New Johannesburg Forced Migration Studies Programme, University of the Witwatersrand

Despite such commitments, it is not certain that rights and protections guaranteed in law will actually be provided in practice.

This study seeks to identify and analyze the obstacles faced by forced migrants when trying to access basic health care services in South Africa and how, if at all, they creatively negotiate such constraints in order to gain improved access.

This study investigates this issue with reference to a particular forced migrant community in a part of the City of Johannesburg, South Africa. It reports and analyses the findings from detailed qualitative interviews with a sample of Somali forced migrants living in Mayfair, a suburb on the Western part of the inner city of Johannesburg. To give a different perspective on the same issue, a sample of health care personnel from clinics and hospitals in and around the Mayfair area were also interviewed. This report compares and contrasts the perspectives of these health care personnel with those of respondents from the Somali forced migrant community. Although this study confirms many of the constraints typically expected, it also arrives at some interesting conclusions about the nature and reasons behind the perceptions of access constraints held by forced migrants.

1.1 Background

1.1.1 Categories of migrants

The migration of people for different reasons deems it necessary to distinguish between different categories of migrants. It can be said that there are three major kinds of migrants: economic migrants; internally displaced people (IDPs); and Forced Migrants.

Economic migrants are people who move with the explicit intention of securing opportunities to improve their livelihood. This movement can take place both internally and between countries. In South Africa the bulk of economic migrants are those who have left rural areas in pursuit of work in cities and towns. While much of this movement has taken place within South Africa, there are a growing number of cross-border economic migrants in South Africa. Cross-border economic migrants are not entitled to the same services and opportunities as those guaranteed to forced migrants.

Internally displaced people (IDPs) are classified as those people who have moved within their own country for reasons beyond their control. Two major causes of internal

displacement are political instability and natural disasters. South Africa does not have to manage a context of internally displaced people.

The term 'forced migrants' is used to describe people who have moved across borders for reasons beyond their control. Often this category of migrants has fled to escape persecution and political instability in their country of origin. The involuntary nature of this migration has come to mean that forced migrants are recognized as particularly vulnerable and in need of protection. South African law differentiates between two categories of forced migrants, 'refugees' and 'asylum seekers'. The term refugee is used to describe a forced migrant whose application for refugee status and its related benefits has been approved. In South African law, any person who is awaiting the outcome of their application for refugee status is classified as an asylum seeker.

Because of the conditions they have fled from, forced migrants are recognized as particularly vulnerable and in need of protection. The nature of displacement and the extreme vulnerability of displaced people have created a moral imperative to respond to the crises. However, even when this moral imperative is recognised, many governments have been constrained in their ability to respond. One of the greatest constraints has been a scarcity of resources to provide newly, and often temporarily settled people with a level of public goods equal to that enjoyed by longstanding citizens of a country.

Available literature has tended to focus on international conventions and the legal rights of forced migrants to social services, without acknowledging the gap between states committing not to violate such rights and states having available resources to provide for such international rights and obligations.

While countries are able to recognize the vulnerability of forced migrants, many are not positioned to provide refuge and protection. Others are able to provide refuge but do not have sufficient public resources to provide anything more than that. A third group have the capacity to provide refuge and protection but for whatever reason, are limiting their obligations.

Those countries with limited public resources face a dilemma. First, should refugees be given protection and care when it is already extremely difficult to provide a basic level of public service to every citizen? Second, what level of public service are refugees entitled to?

These two questions are especially important when considering the obligation and ability of states to provide socio-economic goods and services to forced migrants.

1.1.2 South Africa's Obligations towards Forced Migrants

In September 1993, an agreement was signed between the UNHCR and the South African government, marking the beginning of a relationship in the management of refugee-related issues. This was the first formal agreement concerning refugee affairs, entered into on the part of the South African government which committed the government to opening the country to the acceptance of refugees. The passing of the Refugee Act in 1998 represented the first action on the part of the democratic government to provide access to basic health and social services for refugees.

It seemed then that South Africa, with its wealth of opportunity and its now open, democratic and human rights oriented dispensation, would be an ideal destination for refugees. Statistics provided by the Department of Home Affairs indicate that South Africa received 135828 applications for refugee status in the period between January 1994 and June 2003. These statistics are incomplete and do not include all data from the Durban and Braamfontein reception offices. It is likely that the number of applications received nationally is far greater than this. These figures tell us that South Africa was perceived by many refugees as an attractive destination.

This research report will focus specifically on the gap between theory and practice which exists in the provision of access to basic health care services for forced migrants in South Africa. This issue will be examined through the experiences of a very specific forced migrant community.

1.1.3 The Somali Community in Johannesburg

The Somali Community constitutes the second largest forced migrant community in South Africa. In the period 1994–2003, 10 944 applications for refugee status were lodged by Somali people. The only greater forced migrant population is that of the Democratic Republic of Congo (DRC). Asylum seekers originating from the DRC lodged 22 166 applications for refugee status in the same period. The size of the Somali community makes it a relevant community to study.

The Somali forced migrant community is characterized by high levels of identification

with their ethnic group, and limited external interaction with 'host' communities in the urban setting where they have settled. Data from the Urban Johannesburg Project, a large study of forced migrant experiences and attitudes in 7 centrally located neighbourhoods in Johannesburg, tells us that 54.2% of the Somalis surveyed would put themselves at physical risk to defend their ethnic group. This strong sense of ethnic identity is also evident in that 45% of the Somalis interviewed for this study had no interaction with anyone other than their own nationals. The bulk of those who interacted with South Africans did so for business or employment only. Despite settling in Mayfair because of the Muslim population, there is little to no evidence of interaction with South African Muslims living nearby. This suggests a picture of a community that is relatively insulated and isolated. This characteristic may have major implications for the ability of Somalis to claim socio-economic rights guaranteed in law.

1.1.4 South Africa's Health System

Since the inauguration of a democratic government in 1994, the South African government has been faced with increasing resource challenges. In particular, the health system saw the abolition of user fees, aimed at making health care more accessible to the poorer population. The subsequent increase in the uptake of health services has resulted in the health system being under-resourced and overstretched[2]. Many facilities are operating without a full staff complement and are faced with severe resource shortages. At the same time, South Africa is faced with a rapidly spreading AIDS pandemic which has grave implications for resources which are already over-stretched.

The introduction of the District Health System sought to remedy this problem. The DHS has gone some way in redirecting responsibilities for primary health care to clinics and attempting to ensure that hospitals are only used for secondary care. These resource constraints have contributed to a general perception that limited resources should be used for the South African population, and that foreign migrants should not be the recipients of any level of health care.

Despite these resource constraints, the right of forced migrants to health care access, their health care needs, and the importance of migrants having access to public health

[2] Barron, P., Monticelli, F. (eds) (2003) Lessons learnt in the implementation of Primary Health Care: Experiences from Health Districts in South Africa. Durban: Health Systems Trust.

care cannot be underestimated or ignored. The transient nature of migration, as well as the fact that many forced migrants may have recently left countries where social services were disrupted, and so where little to no health care was available, makes migrants susceptible to compromised immunity[3]. They are therefore vulnerable to a particular set of infections and diseases, such as malaria, yellow fever, typhoid or cholera. Secondly, foreign migrants in South Africa are self-settled and live among South Africans. Living in close proximity to anyone who lives in a deteriorating urban environment and often unfavourable socio-economic conditions is a health risk. Whether they are South African or not is immaterial. These two factors provide strong motivation for forced migrants being able to claim and receive the right to health care guaranteed in the Refugees Act.

The reality of an already overstretched health system poses a major challenge as to the most effective use of already limited public resources.

1.2 Rationale

1.2.1 Adding to the scholarship on access to health care in self-settled urban contexts

This research study is motivated by the wish to contribute to a fairly limited literature on migrants' experiences of health care systems, and of their experiences in self-settled urban settings. Literature concerning health issues among forced migrant populations has tended to be epidemiological, focusing on the patterns of their particular health care problems, given disrupted social services in pre-flight and in-flight circumstances. It has also tended to focus on refugees in camp-based settlements as an easily accessible study group. This study will make a contribution to the growing literature about self-settled urban refugees and the particular socio-economic challenges they face when negotiating the urban environment.

1.2.2 Negotiating the 'dual imperative' in refugee studies

Much of the literature in the field of refugee studies has been concerned with documenting the manner in which refugees are unable to secure adequate livelihoods in

[3] Messele, A (2001) Access to health services for refugees and asylum seekers : Experiences and views of women refugees and asylum seekers living in Redbridge, Waltham Forest – report of a focus group Faculty of Health, South Bank University

their host countries because of the discrimination and injustice they face. This approach has tended to be used as a way of exacting a policy response to alleviate the plight of refugees[4]. Work of this kind has tended to campaign and advocate for the vulnerability faced by forced migrants.

At the same time, this style of activist academia has done little to secure respect in the academy. In essence, the normative cause-based approach can only serve the intention of securing sympathy and access to much-needed resources.

This means that those who are writing in the field face a double-edged sword. How can they write dispassionate analyses that contribute to robust academic scholarship, while at the same time helping to improve the access to resources that will alleviate suffering of those they are studying, a form of writing that of necessity advances normative arguments?

This research tries to negotiate this difficult dual imperative. It does contribute to an existing literature which systematically documents the inability of refugees to access social services. However, it also tries to avoid the trap of the purely normative cause based approach. The study does this by not taking forced migrants' stated perceptions of limited access purely at face value, but rather *comparing* the perceptions of migrants and doctors as to the reasons for lack of access, and closely *interrogating* what constraints migrants say they experience, in order to determine as far as possible to what extent stated constraints are perceived or real.

In addition, the study tries to give more attention than typically found in the literature to the *agency* of forced migrants in these settings, documenting not just how they 'suffer' a set of health care problems or barriers to care, but also how they act to overcome their particular constraints.

1.3 Research Questions

This study is concerned with the ability of forced migrants to access health services in South Africa, either from the formal public health system or from alternative sources of

[4] Jacobsen, Karen and Loren B. Landau. 2003. 'The Dual Imperative in Refugee Research: Some Methodological and Ethical Considerations in Social Science Research on Forced Migration.' *Disasters*. 27 (3): 95-116.

informal, community based care. In particular it is interested in the practice of exclusion at the points of service delivery and how, if at all, migrants try to overcome these constraints to access.

This issue will be explored through the following specific questions:

1. How is South Africa's health policy, when read in conjunction with the Refugees Act, being practically applied in relation to forced migrants in health facilities that Somali forced migrants try to access? How does the policy, or the way it is implemented at facility level, enable or constrain forced migrants' access to health services?

2. To what degree, and in what ways exactly, do forced migrants perceive that they are not able to access formal health care services as a result of the policy or way it is implemented? To what extent do migrants attribute these barriers to their identity as forced migrants?

3. How do health personnel perceive access constraints, and what are the areas of similarity and contrast in how they perceive the constraints identified by migrants?

4. When forced migrants see constraints in accessing the formal system, how do they negotiate these constraints through creative strategies to remove or circumvent the obstacles? Are there typical patterns in the strategies to secure formal access, and which strategies seem most or least successful?

Two initial hypotheses have been identified for the study.

- There are Somali doctors and nurses providing particular health care services to Somali migrants outside of the structure of the formal health system
- Traditional medicine is used by Somali migrants to treat basic health problems without having to use clinic services

1.4 Methodology

This study aimed to investigate the patterns of constraint which determine and shape the access Somali migrants have to health care services in Johannesburg.

The study sought to do this through interviewing both medical practitioners working in health facilities in Johannesburg and Somali migrants living in close proximity to Mayfair, a predominantly Muslim community in Johannesburg.

The research topic emerged out of an observation that increasing numbers of Somali migrants were using Coronation Hospital and Helen Joseph Hospital. I became very interested in how they utilised the health care system and their ability to access appropriate levels of care. The second impetus for the study came from a similar curiosity on the part of the medical practitioners working at Coronation Hospital. Based on this, I decided to pursue my interest by comparing the perceptions and experiences of medical practitioners and migrants, in providing health care and utilising the health system, respectively.

The nature of the research populations are quite different, requiring that different sampling methods be used. The sampling methods which were used were also determined by the ability of the researcher to gain access to the research populations.

Coronation Hospital has two major departments. These are Paediatrics and Obstetrics and Gynaecology.

1.4.1 Study Design

The study sought to investigate and describe the obstacles faced my forced migrants when using the health system in Johannesburg. Secondly, it sought to understand and compare the experiences of health personnel providing care to Somali migrants.

The descriptive nature of the study necessitated that a Qualitative Research Design be employed. This study design is concerned predominantly with exploring and interpreting social life, in terms of the meanings ascribed by research participants[5]. This design enabled me to investigate such experiences and locate them within a particular cultural framework. The influence of and the importance attached to culture can not be ignored when studying the Somali community. It is a factor which influences and shapes gender roles and patterns of interaction both within the community and the outside world.

A second important aspect of the Qualitative Study Design is that it recognises that each

[5] Neuman, W L (1997) Social Research Methods Massachusetts: Allyn & Bacon

person's meaning and reality is subjective and shaped by the context in which it is located Experiences cannot be analysed without considering the context in which they occur[6]. Unlike Quantitative Research, the Qualitative Approach is not concerned with testing existing concepts through statistical analysis. Instead, it focuses on analysing themes as a way of understanding human behaviour.

1.4.2 Research Site

The majority of Somalis in Johannesburg live in and around the areas of Fordsburg and Mayfair. These areas are historically 'Indian' areas with a large Muslim population. Over time, many South African Muslims have moved out of Mayfair to more affluent suburbs and the area has become home to increasing numbers of Somali migrants.

There are two major public hospitals located in close proximity to Mayfair and the surrounding areas. These are Coronation Hospital and Helen Joseph Hospital. Coronation Hospital provides care to women and children, while Helen Joseph is a larger facility and provides services for men, women and children. It also provides a greater battery of more specialized services.

These two hospitals are perceived to be 'more open' and more tolerant towards foreign migrants than other hospitals in the Greater Johannesburg area[7]. This makes the two hospitals particularly interesting to study. While the study was initially going to be based in Helen Joseph Hospital, it was easier to gain access to health personnel at Coronation Hospital. This may be due to the hospital being smaller and my existing working relationships with doctors in the hospital.

Though the study did not interview health personnel from Helen Joseph, many of the Somali migrants interviewed reflected on their experiences of using both Coronation and Helen Joseph Hospitals. As Coronation Hospital and Helen Joseph Hospital form part of the same complex, many doctors from Coronation Hospital were able to reflect on their perceptions and experiences of access constraints in both facilities.

[6] ibid
[7] Interviews with staff of Jesuit Refugee Services, Informal discussion in Forced Migration Working Group, Wits University, August 2004.

1.4.3 Sampling

One of the major obstacles that many researchers are faced with is gaining access to the population they wish to study. This is a particularly important issue when studying forced migrants. The nature of forced migration and the vulnerability that many forced migrants feel can make refugee populations very difficult to access.

Accessing Somali Forced Migrants

Gaining access to the Somali population proved difficult. I was familiar with the Mayfair community but unsure of the networks and relationships which exist in the community, and how these networks may be constrained by tribal conflict. After approaching Jesuit Refugee Services (JRS) I was referred to a refugee who had been in South Africa since 1995 and was employed by JRS as a home based care worker.

She agreed to identify an appropriate sample and to translate for the interviews. It is acknowledged that using a research assistant from the same community in which the study is being carried creates potential for bias during translation. This was considered to be a secondary concern due to the difficulty of accessing the community itself.

Due to the difficulty of gaining access to the population, Snowball Sampling was used. It is recognised that utilising this method of sampling can lead to a sample that is not representative of the general population[8]. As the study did not seek to generate statistical findings, this was considered not to be a major issue.

Twenty Somali Migrants were interviewed for the study. Ten of the Migrants were women. Their ages vary between nineteen and sixty four years old. Three of the ten women are recognised refugees.

Ten men were interviewed. Their ages vary between twenty two and sixty four years old. Seven of the male migrants interviewed are recognized refugees.

Nineteen of the migrants interviewed were interviewed in their own homes. One of the female migrants was interviewed at the home of the research assistant for fear of her husband's response. All of the interviews were conducted in the presence of the research assistant, irrespective of whether the participant could communicate in English.

[8] Bloch, A (1999) Carrying out a Survey of Refugees: Some Methodological Considerations and Guidelines. *Journal of Refugee Studies*. 12 (4) 367-383 Oxford: Oxford University Press

A descriptive list of the Somali forced migrants interviewed, including some biographical details, is included in Appendix 1.

Accessing Medical Practitioners

After permission was granted by the hospital for the study to take place, doctors were approached in the Paediatric and Obstetrics and Gynaecology departments. A list was circulated for those doctors willing to participate. The bulk of doctors who responded were those working in the Paediatric Unit. While conducting the interviews, it came to my attention that very few Somali children were being seen in the Paediatric Unit. As the study sought to investigate both the perceptions and experiences of doctors treating Somali Migrants, this was not considered to present a major problem.

The bulk of Somali migrants visiting the hospital were women making use of ante natal services in the Obstetrics and Gynaecology Unit. This raised questions for me as to why many doctors working in the Obstetrics and Gynaecology Unit were reluctant to participate. It was subsequently suggested to me by a doctor working at Chris Hani Baragwanath Hospital that this unit was known to be one of the most discriminatory in Johannesburg.

During the interviews, it became clear that the second major point of interaction between the migrants and the South African Health System was at the primary health care clinics, where women were taking their babies for growth monitoring and to receive family planning services. I approached the Operations Manager at Mayfair Clinic requesting to interview 2 nurses and a clerk. I was told that I needed to approach the Regional Manager who was opposed to the research. It subsequently came to my attention that one female Somali migrant had lodged a complaint with the police as to the way she was treated at this clinic. This may explain their reluctance to participate in the study.

Ten health personnel were interviewed for this study. A brief description of each is included in Appendix 1

1.4.4 Data Collection

Interviews were conducted using a semi-structured interview schedule. Doctors were asked to reflect on their experiences of treating Somali Migrants. The doctors were asked to identify why they thought Somali Migrants were using Coronation Hospital and any

obstacles which prevented medical practitioners from being able to provide comprehensive health care services to this group. This was done by means of a grid reflecting values of true, false or unsure. The same grid was used with Somali Migrants. This allowed me to compare the responses of the two groups.

The decision to use a semi-structured interview schedule was motivated by the need for flexibility during the data collection process. I recognised early on that this topic was likely to generate much opinion and story telling on the part of forced migrants. The research interview provided for some forced migrants, a means to debrief and to 'have one's story told'. I would need to allow time for this. I went into the interview process expecting this and accepted that providing a listening ear would be my offering to those who were interviewed. At times, it became difficult not to become preoccupied with stories and incidents of discrimination and xenophobia.

During the interviews, interviewees began to reflect on their experiences in other hospitals and clinics in Johannesburg. Coronation Hospital provides services to women and children. The other major public hospitals, such as Johannesburg Hospital, Helen Joseph Hospital and Chris Hani Baragwanath all cater for men, women and children. As a result of this, I decided to extend the study to include male Somali Migrants. This would enable me to explore more closely gender and age as a factor in quality of care.

1.4.5 Ethical Considerations

David Turton argues that research into vulnerable groups and their life circumstances can only be justified if the research is directed at improving their life circumstances. It is this approach which has contributed to the emphasis on ethical research in the field.[9]

At the outset of the study, it was agreed that the findings of the study would be made available to the hospital. All of the health personnel were informed that the study would be made available on completion. It was hoped that the study would result in greater awareness as to the constraints faced by migrants, and that this awareness may address some of the obstacles identified by the migrants interviewed. As the hospital serves foreign patients from many countries, it was assumed that the findings could be considered for all migrant groups.

[9] Turton, D in Jacobsen, K and Loren B. Landau (2003) The Dual Imperative in Refugee Research: Some Methodological and Ethical Considerations in Social Science Research on Forced Migration *Disasters*. 27 (3): 95-116.

The Somali migrants who were interviewed were also told that the findings of the study would be provided to the hospital, and that their experiences would be recorded as part of the study. Both these aims were directed at the study realizing some possibility for change. It was communicated very clearly to the migrants interviewed that the study was unlikely to realize a change in policy.

Three of the migrants interviewed felt that it was important enough that the hospital know about their experiences, even if the study did not bring about a shift in policy.

One of the ethical issues which were identified at the start of the research was the possibility that the study may generate findings that Somali migrants were engaging in illegal activities to gain access to the formal health care system. This issue did not materialize. The extent of illegal activities identified was paying bribes to guards and clerks to obtain care. This is a problem which is broadly recognized across NGOs and the available literature in South Africa.

1.4.6 Limitations and adaptation of the study to constraints

Locating the study within Coronation Hospital may have meant that the perceptions and experiences of doctors would relate predominantly to women, and to barriers faced by female forced migrants when trying to seek reproductive health care. There is a large body of literature which devotes much attention to reproductive health care.

I wanted this study to make a different contribution to the literature. It was this motivation which led me to include an equal sample of men in the study. All of the men interviewed had been to a public health facility in Johannesburg, either for themselves or accompanying someone else. Some of the men also regularly act as translators. Including men in the study would also enable me to consider the impact of gender upon access.

I tried to gain access to the Mayfair Clinic in order that I be able to get a better understanding of the constraints faced by migrants when seeking health care. Problems within the clinic, as discussed earlier in the text, prevented me from being able to do this. The Clinic Manager had a pending complaint lodged against her for discrimination in her treatment of a Somali woman. For this reason, the management were not prepared to allow me access to the clinic staff.

One of the major limitations of this study is the lack of representivity among health

personnel. There were more Paediatric doctors who were prepared to participate in the study, even though the majority of female Somali migrants using the hospital were making use of the Obstetrics & Gynaecology Unit.

It became clear during the data collection process that the experiences of migrants at the Mayfair Clinic were as important as their experiences utilizing hospitals in Johannesburg. The study would have benefited from interviewing nurses working in the Mayfair Clinic. This would have helped to gain a clearer understanding of the nature of the constraints reported by migrants.

It came to my attention early in the data collection process that many of the constraints identified by migrants were related to the behaviour of clerks and administrators. Unfortunately, it was not possible to gain access to these staff because they fell under the management of the administrative authority in the hospital, who were likely to oppose the study because of its potential findings[10].

Given that the migrants interviewed reflected on their experiences across facilities in Johannesburg, it would have been useful to have spoken with health personnel working in these facilities. However, the size and scope of the study did not make this feasible.

1.5 Structure of the report

This research study is divided into eight chapters. The chapters have been structured in order that they may follow in a logical manner.

Chapter 2 provides a discussion of the three key bodies of literature that have implications for the study. The review assesses these literatures and their relevance for the study. It also identifies and discusses gaps in the literature to which this study can contribute.

Chapter 3 provides a clear description of the community being studied. This description will look at the defining features of the Somali community in Johannesburg, with

[10] The report was likely to raise and identify practices of xenophobia and discrimination by staff that would compromise the reputation of Coronation Hospital. In particular, gaining permission from the Superintendent was much more difficult than securing the participation of some doctors within the facility.

particular reference to data provided by the Urban Johannesburg Project survey of 2003, one of the first to focus specifically on the experiences of self-settled refugees. This chapter also includes a brief description of the formal health system which migrants are trying to access.

Chapter 4 provides an analysis of the detailed qualitative interviews conducted with migrants about their perceptions and experiences of constraints when trying to access the formal health care system. This chapter begins to analyse the perceptions of migrants as to reasons for constraints experienced when accessing health care.

Chapter 5 interrogates the perceptions of doctors as to the nature of constraints faced by migrants. It looks closely at areas of agreement and disagreement between doctors and migrants as to the nature of constraints, and any attempts by doctors to improve access.

Chapter 6 discusses adaptive strategies and methods which migrants employ to gain access to the health care system. In particular, the chapter notes the particular kinds of strategies employed by migrants, and which are most or least successful.

Chapter 7 is the closing chapter to the report. It provides some conclusions and draws together the findings of this study. The chapter also briefly discusses the implications of this study for both policy and practice as well as further academic study in the field.

Chapter 8 provides a catalogue and description of each of the respondents interviewed for the study. The description of migrants interviewed is extensive and provides detailed biographical information. This is because each biographical detail impacts upon their perceptions and experiences of access constraints. The description of doctors records the unit they work in and when they were interviewed.

2. LITERATURE REVIEW

This research study engages a number of different areas of thinking and scholarship. It is located within three broad fields of thought: refugee studies, socio-economic rights and public health. First, the study has relevance for refugee studies because it investigates the experiences of forced migrants negotiating their lives in the countries to which they have fled. Second, the study engages the literature pertaining to socio-economic rights by looking at the practical experiences of forced migrants seeking to claim rights which theoretically belong to them. Thirdly, it is of great importance for public health because it examines the impact of health status on surrounding communities and the ability of vulnerable communities to access health services.

The study has been informed by different aspects of these literatures, but it is also conscious of the weaknesses that exist. This study will seek to contribute to the literature, both by reinforcing some key conclusions that have been reached in past work on refugee access to socio-economic rights, specifically to health care, and by trying to address some of the gaps in this work.

2.1 Refugee Studies

It is recognized that Refugee Studies is a broad field. It spans some three decades of writing on refugee situations and conditions all over the world. This assessment of the literature does not reflect on all of this writing. Rather it is concerned with one particular theme that is often dominant in the field of Refugee Studies.

Refugee Studies devotes much attention to recording the discrimination and the injustice which refugees experience, both in their countries of origin and in the countries to which they have fled. This literature consists mainly of case studies of refugee populations living in camps throughout the world. This literature has been labeled by some as being normatively over-determined, in that much of it has sought to represent the plight of refugees as a way of campaigning for 'better treatment'. In the process it implicitly assumes refugee status as the defining feature of all experiences and interactions that forced migrants participate in. This approach ends up suggesting that any negative experiences or interactions encountered by forced migrants arise from and can be fully attributed to their identity as a forced migrant.

One such article is an article by Hughes (2003) which looks at refugee policy in Yemen[11]. The study proposes that the government has failed to take appropriate policy action to secure the rights of refugees. While Yemen is a country which is considered to have a fairly liberal and progressive attitude towards refugees, national law to protect refugees remains limited. The author states that the absence of legislation pertaining to forced migrants tends to create a situation where forced migrants are treated no differently to non-nationals – who have far less rights to goods and services than those theoretically accessible to refugees. The author suggests that this policy void constrains the ability of refugees to claim socio-economic rights.

The situation in South Africa is somewhat different. While there is legislation which clearly stipulates and commits to the provision of certain protections and access to resources., the same barriers to access exist. Hughes attributes the barriers to access to the structure of the refugee system in Yemen, different cultural understandings of refugees and the host population, racism and xenophobia perpetrated against refugees by citizens of Yemen.

The issues raised in this article resonate with the experience of many refugees in South Africa. However, like many other articles in the field of refugee studies, it is directed at securing recognition of the hardships faced by refugees without moving beyond this position to one of analysis or critical engagement with the issues.

Some articles in the field are a bit more nuanced and do not assume 'refugeehood' as the only explanatory variable. They interrogate the assumption that 'refugeehood' is automatically the key defining characteristic of personal experience, and arrive at some interesting outcomes. One such study is an investigation by Ascoly et al (2001) into the experiences of self-settled female forced migrants in the Netherlands.[12] The study notes three major factors which significantly influence the ability of women to gain access to health care services; that of being a non-national, a refugee and a woman. These three elements can act as major obstacles to female forced migrants accessing health care. The first element that of being a non-national would suggest that society is structured by the exclusion of particular groups. Some of the excluded groups may include immigrants, minority groups or those with low socio-economic status.

[11] Hughes, N (2003) Yemen and Refugees: progressive attitudes – policy void? *Forced Migration Review* (16) www.fmreview.org/FMRpdfs/FMR16/frm/16.12pdf
[12] Ascoly N, van Halsema I & Keyser L (2001) Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands *Journal of Refugee Studies* 14 (4) 371-393

Such exclusion can take the form of explicit policy and criteria or it may be less obvious, such as lacking knowledge of how the health system is organized and what services are available. Whereas the first practice is explicitly intentional and implemented by individuals, the second is not so easy to quantify and may not be intentional. By many, the first approach may be seen as a valid way of managing states resources. This is especially so when a non-national is not considered to be in any way vulnerable or in need of assistance and support. Their migration to a new country is often perceived as resulting from a choice taken by themselves alone and not in any way due to the actions of others.

The term non-national has also tended to be used as a way of lumping together all immigrants irrespective of their legal status. In many instances, people are unable to distinguish between different migrant groups[13]. This is particularly problematic where each migrant group has different rights. Often, legally recognized refugees are confused with illegal immigrants and denied access to services which they are rightfully entitled to.

The nature of being a refugee and what protections refugees are entitled to is more complex. It is widely recognized that forced migrants are a vulnerable group and in need of protection. But this recognition does not always translate into a commitment to provide anything more than refuge.

In countries were the right to basic services is entrenched in law, there are many incidents of refugees being unable to access such basic services. Where states provide different levels of service for refugees and forced migrants, people remain vulnerable while they await the outcome of their asylum application. This vulnerability does not refer only to health care, but also being able to receive education, obtain employment and open a bank account. It is this protracted uncertainty which can constrain the ability of women to gain access to reproductive health care.

The study conducted by Ascoly et al identifies that the third major constraint that women face when trying to access health care is their gender, and how social roles or cultural expectations prevent women from being able to have their health needs met through the formal health care system.

There is a common sense assumption that the health status of refugees in host countries

[13] Crush, J (2000) The Dark Side of Democracy : Migration, Xenophobia and Human Rights in South Africa *International Migration* 38 (6) 103-119

is especially poor because they can not gain access to health care. Many forced migrants will have fled countries where health and social services have been disrupted for some time. Despite lacking access to comprehensive health care, the health status of forced migrants may improve in a functioning host country. However, this improved health status can not be maintained where refugees are living in poor socio-economic conditions. [14]

2.2 Socio-Economic Rights

The literature on socio-economic rights is extensive. A far smaller proportion of it applies to the unique conditions facing forced migrants. In addition, the literature that does exist is mostly oriented towards analyzing the lack of access to socio-economic rights *in law* of forced migrants. There is very little analyzing access *in practice* once forced migrants have managed to get their status as refugees legally recognised and their rights to a set of socio-economic protections enshrined in the law.

The term Human Rights is understood to encompass inalienable rights, civil and political rights and socio-economic rights, in this category of importance. It is common practice that civil and political rights are restricted to citizens or naturalized persons, whereas inalienable rights belong to all people, irrespective of their citizenship. The question of who is entitled to socio-economic rights is a complex one. Forced migrants often arrive in their host country with nothing and lack the means to care for themselves. Many have come from areas with disrupted social services and require health care on arrival. At this level, it becomes difficult to determine eligibility, particularly when there is such a strong motivation for providing forced migrants with health care access.

A case in point of literature that analyses socio-economic rights in law is Nadasen (2001)[15]. This book looks closely at socio-economic rights, and in particular the interdependent relationship between human rights and the right to health care. This interdependent relationship is particularly important. A large body of literature within the field of human rights concentrates specifically on inalienable rights such as the right to

[14] Messele, A (2001) Access to health services for refugees and asylum seekers : Experiences and views of women refugees and asylum seekers living in Redbridge and Waltham Forest – report of a focus group Faculty of Health, South Bank University
[15] Nadasen, S (2001) Public Health Law in South Africa Butterworths

life, right to freedom of movement, freedom from torture and the right to equality[16]. Some of the literature has tended to adopt the position that because a government is not violating universally recognised inalienable rights, they are seen to meet their commitment and obligation to uphold and protect human rights.

It is increasingly being recognised that socio-economic rights are not independent of human rights. The right to life implies the right to a certain level of health and wellbeing and infringing upon the right to health care, is by implication, compromising ones right to life. The very nature of forced migration is based upon the violation of human rights in the country of origin. Theoretically, this should mean that the host country is able to provide for and protect refugees from violations endured in their country of origin. .

Secondly, socio-economic rights all involve the delivery of particular goods and resources. The structure of the South African government is one which allows for the division of policy making and implementation to be shared between the spheres of national, provincial and local government. Conventionally, national government is responsible for the drafting of legislation and policy making, whereas the responsibility of implementation may fall to provincial and local government.

The nature of migration means that it is often difficult to establish the size of the forced migrant population in Johannesburg. Budgetary allocations for health facilities are often based upon the size of the population the facility serves. This lends itself to a situation whereby hospitals are serving a far greater population than they had planned for and have insufficient budget to do so. This can easily lead to a situation where provincial government is faced with covering the costs of a policy decided at national level.

Each health facility in Gauteng is accountable for its own budget and level of spending, to the extent that management are often held accountable for overspending. This scenario further discourages access for migrants, particularly when providing such access runs the risk of 'getting into trouble' about the management of ones budget.

Some scholarship regards the provision of socio-economic rights as an extension of the commitment of host states to provide protection for forced migrants.[17] This has direct

[16] de Waal J, Currie I & Erasmus, G (2001) The Bill of Rights Handbook (4th ed) Lawyers for Human Rights and The Law Society of South Africa

[17] Hathaway, J (2001) Temporary Protection of Refugees: Threat or Solution? in Handmaker J, de la Hunt L & Klaaren J (2001) Perspectives on Refugee Protection in South Africa A LHR online publication. www.lhr.co.za/refugee/book/contents.htm

implications for host countries. A country like South Africa has signed the 1951 Convention and committed to accepting refugees. By virtue of being a signatory to the Convention, the South African government has a weight of obligation to uphold it. However, the commitment to providing some level of access to rights and services for migrants was only ensured in the Refugees Act. The idea that accepting refugees automatically commits one to the delivery of socio-economic rights is very problematic. The majority of the world's refugee population are settled in Africa, a continent with already limited resources to provide for the needs of their own nationals. The evolving capacity of the African state deems it imperative that states are able to determine the parameters of protection they wish to make available to non-nationals.[18]

The importance of access to health care for forced migrants is acknowledged widely. But limitations in the availability of resources prevent the full realization of this right. The principle of *progressive realisation* is fundamental, yet ambiguous. In the same moment, it requires the state to commit to the delivery of a set of services while also providing the fallback that the state meet its obligation in the context of available resources.[19]

Research conducted by CASE for UNHCR documents in detail International Covenants and Declarations which govern the rights of refugees and the provision of socio-economic rights more generally. While all of these Covenants and Declarations commit to the delivery of socio-economic rights, the capacity of the state to meet the needs of its own population will determine the extent to which the socio-economic rights of migrants can be upheld. However, it can not be assumed that because states lack the capacity to meet the needs of their entire population, that they have no responsibility for ensuring an acceptable level of health and health care for forced migrant communities.

The concept of Human Rights and the idea that Human Rights entitle people to particular goods is very controversial. Any right which deals with the provision of goods is subject to limitations and resources. Evidence from this study suggested that migrants believe their human rights and their refugee protection, guarantees them the right to health care, education and social security. This impression is fuelled by the perception

[18] Belvedere F, Pigou P & Handmaker J (2001) REALISING RIGHTS: The development of health and welfare policies for asylum seekers and refugees in South Africa Commissioned by UNHCR. Published by CASE

[19] Heyns, C & Brand, D (`1997) "Introduction to the Socio-Economic Rights in the South African Constitution" Socio-Economic Rights Project University of Pretoria

that the South African government is funded by the UNHCR and therefore must have money to meet their needs.

Migrants who were interviewed for the study frequently commented that health staff do not understand the situation in Somalia and do not recognize their right to health care. Implicit in this belief was the assumption that having protected human rights was a guarantee to a better level of resources and protection than those whose rights have not been violated, and in this instance the host population. There seemed to be very little understanding of the Refugees Act and the nature of socio-economic rights. The majority of forced migrants located their rights within a human rights framework, and only a few understood their rights to *access* in terms of the Refugees Act.

2.3 Public Health

The bulk of the available literature which explores access to health care investigates the experience of accessing health care in camp-based settlements. The dynamics of using health services in camps differ significantly from the experiences of self-settled communities. Camp-based health services tend to be highly structured and designed specifically for relief or emergency situations. Much of the available literature is concerned with health problems which arise out of emergency situations.

Of the limited research available that looks at health care access, a large part of it is devoted entirely to reproductive health care and the health needs of female forced migrants. This focus has been motivated by the recognition that many refugees are women and that being a female refugee carries with it a particular set of problems and difficulties. Reproductive Health Care provides the lens through which these issues can be studied more closely[20].

The field of reproductive health care has become increasingly important in the context of sexual violence being used as an instrument of war. The atrocities perpetrated in Rwanda, Democratic Republic of Congo (DRC) and Zimbabwe have drawn attention to the risks faced by women during war, and the consequences of reproductive health care not being

[20] McGinn, T (2000) Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives* 26 (4) 173-181

available.[21] This research is located within camp settings and focuses on targeted services. The extent to which access is discussed is by looking at the impact of emergency situations on reproductive health. That refugees are urban-based in South Africa and that we do not have any refugee generating countries on our borders[22] means the contribution of the literature to this study has been to understand better reproductive health risks associated with involuntary migration.

The emphasis in the literature on reproductive health care access has resulted in a situation where the literature has not given sufficient attention to the ability of forced migrants to access basic health services in the urban environment and the constraints which impede access. The nature of self-settled refugee communities is that forced migrants become responsible for ensuring their own safety and securing their own rights, outside of the delivery of core programmes in a camp setting.

Self-settled migrants have to become responsible for ensuring their own access to health care, and the extent to which they are able to meet such needs is greatly influenced by their ability to integrate with their host community. Barriers created by the structure of the health system, language and culture prevent integration of migrants with host communities. This increases potential for isolation and exclusion. Such issues of isolation and exclusion may be greater barriers to access than a situation where only very core emergency and basic health services are being delivered in camp settings.

Research on the need for reproductive health care and access to reproductive health care has often included Somali women in the sample population.[23] This material has proved very useful in beginning to identify key themes and to gain a better understanding of the gender dynamics which exist in the Somali community.

There is very limited literature which looks at the strategies employed by migrants when they are unable to access formal health care. The literature which examines the alternatives to formal health care services concentrates extensively on African indigenous

[21] Schreck, L (2000) Turning Point: A Special Report on the Refugee Reproductive Health Field *International Family Planning Perspectives* 26 (4) 162-166
Heise, L (1994) Gender-Based Violence and Women's Reproductive Health *International Journal of Gynaecology and Obstetrics* 46 222-228
[22] To date, migrants fleeing Zimbabwe have not been recognised as a forced migrant population and consequently receive no protection from the government
[23] Ascoly, N et al. (2001), Messele, A (2001)

healing systems and popular medicine.[24] Both Kleinman (1980) and Feierman[25] (1985) are well-known academics in the field of social anthropology. Feierman looks at the social determinants of health within the context of the broader environment. This concept is very useful when studying forced migrant communities, who by their very nature exist out of a process, albeit violent, of social change. The literature also looks at *patterns of control* that exist within the health system and how such power influences the way patients interact with doctors or health personnel. It is the presence of such authority that can significantly influence how migrants interact with health personnel. This area of study is particularly important when studying the Somali community.

The findings of recent studies differ somewhat to the literature. For example, data from the UJP suggests that Somali migrants continue to use formal health care irrespective of the constraints they face. Interviews for this research report probed the issue in some detail.

Another area of the public health literature which is very important when considering access to health services, is the impact of culture on the way forced migrants understand the health system and interact with health personnel. The importance of cultural awareness and cultural sensitivity in health care can not be underestimated. Many of the barriers which exist in the health system can be attributed to differences in cultural understanding. Some of these differences include a lack of awareness about cultural norms, differing cultural values and differences in the understandings of health and disease.[26] Many times, areas of difference which exist between migrants and the host community are attributed to different cultural understandings and behaviour. Some of these differences in behaviour could include the way a patient is examined and the way the patient interacts with the doctor. It is likely that migrants bring their own perceptions about how health care 'should be' and that such perceptions inform their attitude and experience of the formal health system in South Africa. These cultural differences in understanding and approach highlight the importance of cultural sensitivity and the need to be aware of how culture has the potential to influence health outcomes. Accordingly, this research asked to what extent a lack of sensitivity was an important constraint on access.

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[24] Kleinman, A (1980) Patients and Healers in the context of culture. Berkeley: University of California Press

[25] Feierman, S (1985) Struggles for Control: The Social Roots of Health and Healing in Modern Africa *African Studies Review* 28 (2/3) 73-115

[26] Tjale, A & De Villiers, L (2004) (ed) (2004) Cultural Issues in Health and Health Care Cape Town: Juta Academic

3. HEALTH CONTEXT IN THE STUDY AREA

3.1 Overview of the Somali Community of Johannesburg

Johannesburg is home to many forced migrants, the majority from countries throughout Africa. Some of the largest populations include forced migrants from the Democratic Republic of Congo (DRC), Somalia and the Republic of Congo. A fourth group which is particularly large is former Mozambican refugees who have chosen to remain in South Africa, despite their refugee status having been revoked. It is estimated that there are approximately 300 000 Somali refugees worldwide. Of this number, 160 000 are believed to be in Kenya. It is estimated that South Africa is home to 5000 Somali refugees[27] of which the majority are settled in Johannesburg and Cape Town.

Somalia is also a country which is recognized by the South African government as one of the five main refugee-generating countries on the continent. This has come to mean that the possibility of asylum seekers having their applications turned down is not great. Nevertheless, likely many other asylum seekers, the process of status determination is a lengthy one. Of the migrants I interviewed for my study, all had applied for refugee status. Approximately 55% were recognized refugees. The remainder were still awaiting the outcome of their asylum application. Despite this, 15.5% of the Somalis who participated in the Urban Johannesburg Project (UJP) spent time in a detention centre. The majority (69.5%) of Somalis surveyed had also paid for the documents over and above the normal required fees.

3.1.1 Settlement Patterns

The South African forced migrant population is self-settled and live among South African nationals. This settlement pattern differs from Kenya, Malawi and Mozambique. It is one which allows greater freedom of movement, making South Africa an attractive option to forced migrants. Self-settled migrants are usually better integrated and more self-sufficient than those living in camps.[28] At the same time, it also means that forced migrants need to seek out services themselves, such as education and health care which would traditionally have been provided in camps by aid organisations.

[27] www.refugees.org
[28] McGovern, M (1998) "A Research Proposal Funded by the Social Science Research Council: Identity and the Negotiation of Displacement in Southeastern Guinea, West Africa" *Africa Today* 45 (3-4): 307-322

Though forced migrants choose to live among South Africans, there is a tendency for different migrant communities to settle in particular areas of the city. The areas of Johannesburg with the largest migrant populations are Berea, Bertrams, Rosettenville, Yeoville, Mayfair and Fordsburg. These areas are under-resourced and are characterized by a deteriorating urban environment, with low levels of investment in infrastructure and employment.

This settlement pattern is evident in the large community of migrants from the DRC who are living in Yeoville and Rosettenville. In the same way, the majority of Somali migrants living in Johannesburg are concentrated in and around Fordsburg and Mayfair, suburbs located in the Western area of Johannesburg. Mayfair is home to a large South African Muslim population. While migrants cite this as a reason for settling in Mayfair, there is very little evidence of interaction between Somali people and South African Muslims.[29]

49.2% of the Somali migrants interviewed as part of the UJP stated that the thing they were most pleased with living in Mayfair was that they were close to members of their ethnic and national community.[30]

3.1.2 Living Conditions

Mayfair and Fordsburg are two suburbs populated by many Somalis. They are also areas where there are vast differences in living conditions within the same suburb. Parts of Mayfair are still inhabited by the wealthy South African 'Indian' Population, many of whom run their own businesses as their means of income. Fordsburg shares similar demographics but also has many small shops and traders. It is closer to the Inner City.

While there remain many upper income parts of Mayfair, it is also characterized by many smaller houses and flats previously occupied by South African citizens. There has been very little investment in maintaining such houses, and many of these have become home to Somali migrants. Rent is paid to South African property owners. The UJP tells us that 11.9% of the Somali migrants interviewed have a monthly household income of R1100-R1499, of which between R200-R499 is spent on rent.

[29] Interview with Respondent B, 11 August 2004; Interview with Respondent N, 16 August 2004; Interview with Respondent T, 18 January 2005.
[30] Interview with Respondent N, 16 August 2004

This can be compared to 6.2% of Ethiopians with the same monthly income, but of whom 18.9% are spending R500-R799 per month of rent.

The majority of Somali forced migrants did not leave Somalia with members of their household (55.2%) Data from the UJP tells us that 11.9% of Somali migrants live in households of 3 or 5 members. While very few of the migrants interviewed sent money to friends or family outside of South Africa, many of the migrants interviewed for my study spoke of receiving money from family in the United States of America and the United Kingdom. This money was not always received monthly, but rather for particular expenses.

3.1.3 Networks and Relationships

The UJP tells us that Somali migrants living in Johannesburg still maintain many ties with their country of origin. While many would not defend their country of origin, 54.2% of the participants indicated they would put themselves at risk to defend their ethnic group. The majority (60.3%) strongly agreed that they would like their children to be a part of their ethnic group.

This statistic reflects the nature of the conflict in their country of origin. Many of the participants in this research study identified fellow migrants based on their tribe, but were also insistent that ethnic and tribal affiliations were no longer important in South Africa, and their were many examples of migrants having married someone from a different tribe, since arriving in South Africa. At the same time, reference was also made on more than one occasion to the hierarchy and status which served to divide tribal groups.

This information tells us that despite the discrimination and injustice many forced migrants face, Somali forced migrants would not give up their identity in order to overcome such injustices. It also tells us that the migrant group is still very invested in reclaiming their identity in their country of origin. This is illustrated by the fact that 49.2% of Somali migrants surveyed for the UJP regularly follow political affairs in Somalia.

There is also evidence of the community having close bonds with friends and family members who are located both within and outside of South Africa. 74.6% of Somali migrants surveyed had contacted their kin or family members outside of South Africa

within the last three months. 40.7% of migrants surveyed had contacted kin or family members who are in South Africa in the last month. These bonds are also visible in the fact that the majority live with friends and family from their country of origin. Some of these bonds and connectedness could be attributed to being in a foreign country, away from the familiarity of their home country. Despite there being limited affinity with local mosques and with South African Muslims living in Mayfair, 67.7% said they would defend their religion.

3.2 Typical Health Care Needs of Somali Forced Migrants in Mayfair

3.2.1 Demographic Profile

The Somali Forced Migrant population residing in and around Mayfair is a young one. 34.5% of those interviewed as part of the UJP are between the ages of 25 and 30. While completing my data collection, I also noticed that the population seemed to be predominantly male. Admittedly, this observation could be attributed to men being more visible and moving more freely whereas women may be more likely to remain at home with children.

Research interviews revealed that women and children utilized the health system more frequently than men. Women were using the health system for reproductive health care, and were taking their babies to clinics for immunizations and growth monitoring. Children were being taken to the clinic for minor ailments, and where necessary to Coronation Hospital. This utilization pattern poses very particular challenges to access.

All female interviewees who had children, with the exception of one, had given birth to their children in a South African public hospital. All of the same sample had attended or attempted to go for antenatal care and monitoring prior to the birth. Doctors interviewed for the study confirmed that Somali women are using the Obstetrics & Gynaecology Department of Coronation Hospital more frequently than other departments.

Women

Somali women have diverse health needs. Some of these needs are similar to that of the South African population. But they are also faced with particular reproductive health challenges. Firstly, they originate from a community where family planning is not widely practiced. This has come to mean that many women have children in quick succession,

placing strain upon their bodies. The powerful gender relations that exist in the community also mean that women are often unable to negotiate or control sexual relations with their partner. For many women, when to fall pregnant is rarely a choice. Secondly, Somalia is a country where female genital mutilation (FGM) is widely practised. As a result of this, many women are unable to have a natural birth. Often times, delivery is more complex than that of South African women.

The following case illustrates this;

> *Aysha* is 16 years old. She came to South Africa in 1997 with her family and is unable to speak English. Upon arrival in South Africa she married a Somali man and soon became pregnant. After discovering that she was pregnant, the father of the child discontinued the relationship. Her biological family has resettled in England and have disowned her because of being married at such a young age. The child's father provides no emotional or financial support. Aysha has been staying with her child in the home of a Somali woman who took in her and her daughter, who is now 2 years old. As a result of fleeing Somalia at such a young age, Aysha has no formal education and can not read or write. She can now speak very Basic English.*
> *(* Name changed)*

One issue which affects all migrants but women in particular is exposure to malaria. Almost all the migrants interviewed for this study entered South Africa through Mozambique which is a high-risk area for Malaria. This risk is heightened if women are in their early stages of pregnancy during which the most growth takes place. Some of the consequences for babies of mothers with malaria include low birth weight, maternal anaemia and perinatal mortality.[31]

Another major health issue facing female Somali migrants is that of domestic violence. Many women are attending clinics for treatment of injuries resulting from family violence. Studies tell us that family violence increases in periods of stress and war-time.[32] This stress is not confined to ones country of origin. Often times, the stress of integration and adjusting to a new living environment can be just as overwhelming as the above.

A particular health issue affecting Somali women, which affects few if any of their South

[31] WHO, UNICEF & UNAIDS (2002) Coordinates 2002 Charting Progress Against AIDS, TB and Malaria World Health Organisation
[32] Krause S K, Jones RK & Purdin S J (2000) Programmatic Responses to Refugees' Reproductive Health Needs *International Family Planning Perspectives* 26 (4): 181-187

African counterparts, is female circumcision. However, understandably, it was difficult to probe for details around how this unique but very sensitive health issue plays out in the need to access local health care services likely very poorly equipped to respond to it.

Children

The UJP tells us that 44.8% of Somalis surveyed left their country of origin with other members of their household. Of this group, 6.8 % left with one child and 8.5% left with more than one child.

One of the many features of displacement is disrupted social services and lack of access to clean water. These conditions place forced migrants at high risk of contracting diseases such as cholera, tuberculosis or dysentery. These are all infections stemming from poor living conditions and unsafe sanitation. A child's immune system is less developed than an adult, making them particularly susceptible to illness or disease. Should a child contract such illnesses while fleeing it may be very difficult to obtain the necessary treatment and care. This means that children are likely to arrive in South Africa in need of emergency care.

The second interface between children and the health system occurs at a much earlier age when babies need to receive their immunisations. These are usually administered by nurses in clinics. The ability of a child to have their immunisations and growth monitoring completely correctly can be significantly influenced by the relationship between the nurse and the mother (or caregiver). If a Somali woman is unable to speak English, it will limit communication between the nurse and the caregiver. This will make establishing a rapport difficult and could result in immunisations and growth monitoring being incomplete.

Children are also at very high risk for contracting malaria. Malaria is responsible for 1 in 5 childhood deaths on the continent. In addition to this, 70% of people who die from malaria are children. Malaria may also indirectly cause respiratory complications and diarrhoeal diseases in young children. Some of the consequences of untreated malaria in children include brain damage and learning impairments[33].

Somali people are also genetically more prone to particular illnesses which are uncommon

[33] World Health Organisation (1999) Rolling Back Malaria *World Health Report* chapter 4 Geneva: WHO

in the South African population[34]. Irrespective of whether or not the child or family has recently arrived in South Africa, the genetic predisposition to such diseases means that they are treated in South African hospitals. These infections and diseases tend to appear in the first few years of life.[35]

Men

Somali men suffer from many common health problems which are in no way specific to Somali men or Somali people in particular. However, some Somali men have war-related wounds which require secondary care. For example, while surface wounds may have healed, some are still carrying bullets in their bodies or have infected scar tissue. These wounds may have not been treated in their country of origin because of a disruption in the delivery of health services. Such wounds may also require secondary care that was not available in Somalia during the war.

The following case is illustrative:

> *Hassan* is 28 yrs old. He came to South Africa in 1997 after sustaining a head injury during the conflict in Somalia. As a result, he has a bullet lodged in his head. In 1998 he went to Johannesburg General Hospital in the hope that he would be able to have the bullet removed. The doctors were not able to predict realistically what the likelihood was of the operation resulting in further head injury. He decided not to pursue the operation for fear that it would be unsuccessful as he has no family to care for him should the operation fail.*
> *(* Name changed)*

Four of the ten men interviewed had been themselves or with someone to a hospital to get treatment for injuries sustained in a physical fight. This need is not specific to Somali men.

As with female migrants the incidence of malaria among newly arrived male Somali migrants is high. I met two men during my field work that had both recently passed through Mozambique and had contracted malaria. Both had spent more than one month in the country and had only sought medical treatment upon arrival in South Africa. Armed conflict and migration are recognised by the World Health Organisation (WHO)

[34] Interview with Respondent 8, 3 February 2005
[35] Interview with Respondent 8, 3 February 2005

as two major factors influencing the spread of malaria between countries[36]. Many migrants are moving from areas with low risk for malaria into high-risk malaria areas. Such people are often not immune and therefore at high risk for contracting malaria which, without treatment may progress to cerebral malaria with consequent neurological complications.

Elderly

Many of the health difficulties experienced by the aged require specialist ongoing care. Their weakening immune system makes them more vulnerable to illness and disease. This would be a particular risk while fleeing. There are also common health problems often experienced by the elderly, such as hypertension, diabetes and stroke. These health problems are no different to those faced by elderly South Africans. However, like men in general, some elderly forced migrants suffer health problems associated with injuries sustained in conflict settings much earlier in life. The following two cases are typical:

> *Shaheda* is 64 years old. She came to South Africa in 1996. Her family are scattered in Europe and Africa. She has no family in South Africa. Shaheda sustained 3 bullet wounds during the war. Two of the bullets were lodged in her abdomen. The third is in her lower back. The bullets that were in her abdomen have been removed. Shaheda went to Johannesburg General Hospital in 1997 requesting an operation to remove the last bullet. She was given a commitment in 1997 that she would have the last bullet removed through surgery. This surgery has still not taken place. She now has to receive regular orthopaedic care as her movement and walking have been affected by the injury.*
>
> *(* Name changed)*

> *Faruq* arrived in South Africa in 1999. He is approximately 63/4 years old. He was shot in his back in 1991 and has lost the use of his legs. He lives in a house with male Somali migrants who he previously did not know. He uses a wheelchair. He has no family in South Africa and depends solely on a female Somali migrant to assist him in getting into his chair, going places and getting his groceries. He speaks some English but can not converse easily.*
>
> *(* Name changed)*

[36] World Health Organisation (1999) Rolling Back Malaria World Health Report chapter 4 Geneva: WHO

3.3 Overview of Health Systems accessed by Somali Forced Migrants in Mayfair

South Africa has a two-tiered health system. Each tier provides a different level of service and is administered by different arms of government.

The South African health system is structured such that different levels of care are offered in different facilities. This ensures better use of resources and staffing capacity. Services which are preventive in orientation such as immunisations, family planning and growth monitoring are offered in municipal clinics. Larger clinics provide both preventive and treatment services. This means that people can go there for minor aches, pains or infections that can be examined and managed by nurses.

Municipal clinics fall under the ambit of local government and are administered by regional managers. No fees are charged for clinic services. These clinics are staffed by nurses and assistant nurses on a day-to-day basis. Once a month a psychiatrist or psychologist may see patients. Basic health problems that do not require in patient treatment should be attended to in clinics.

It is only if a particular health issue can not be addressed in a clinic that a patient is referred to a hospital for treatment. Theoretically, no patient should seek health care at a hospital without having been to a clinic, for anything other than emergency treatment. This referral procedure serves to discourage patients from utilising hospitals for health problems which can be managed by nurses. At the same time, it is intended to ensure better use of staff, so that doctors are only dealing with secondary level health problems, most of which require hospitalisation. Referral is one of the core elements of the district health system (DHS).[37]

The DHS became a formal part of the South African health system when it was included in the White Paper on the Transformation of the Health Sector in 1997. It represented an endeavour on the part of the democratic government to make the health system more efficient. The election of a democratic government resulted in the public health system having to accommodate a large indigent population that were previously unable to access health services. The DHS sought to increase the effectiveness of the health system by

[37] Department of Health (2001) District Health System in South Africa, Progress made and next steps (unpublished)

ensuring that health problems were dealt with at the appropriate level of care.

At the same time, it was hoped that the DHS would ensure a move away from a 'hospicentric' system and the accompanying perception that the only way to obtain quality health care was to visit a doctor at a hospital.[38] It was hoped the change in policy would translate into a reduction in the patient overload experienced in public sector hospitals.[39]

The second element to the South African health system is public hospitals. These facilities provide subsidized services to those who do not have medical insurance. The majority of care provided at hospitals is in-patient or specialist treatment. Patients are required to pay a nominal fee to use hospital services, raising the possibility of different fee structures being charged arbitrarily to different classes or categories of health seekers.

Within the hospital system, facilities are allocated a particular classification which refers to the level of care available. The majority of hospitals in Johannesburg are classified as secondary or tertiary facilities.

This classification determines the level of service available and the budget allocated to facilities. Theoretically, there should be more secondary hospitals providing a specific level of in-patient care and less tertiary hospitals providing a higher level of specialist care. These different classifications have direct implications for the way the facilities are used and where patients seek treatment.

[38] Interview with Respondent K, 17 November 2004
[39] Leonard, D K (ed) (2000) Africa's changing markets for health and veterinary services St Martins Press

4. EXPERIENCES OF MIGRANTS OF ACCESS CONSTRAINTS

This chapter will discuss the obstacles to access identified by migrants. For the purposes of the research, the term *access* is defined broadly and does not only refer to a physical barrier in the form of an administrator accepting money and issuing files. It refers also to the ability of forced migrants to receive the same standard of health care as that available to South Africans. The chapter will seek to do this through examining each constraint individually.

The constraints discussed below are the perceptions and experiences of migrants. They are reported as accurately as possible as they were communicated by interviewees, and then evaluated.

4.1 Language and Communication

"Language barriers create problems for both patients and providers and can greatly influence whether care is received, patient compliance and the quality of the encounter"[40]

The inability of migrants to communicate in the language of their host country has major implications for their own health and that of their hosts. Each of these implications presents itself in a different way. These aspects will be discussed further here.

The ability of Somali forced migrants to communicate in English varies widely across gender. While the majority (90% of male respondents)[41] of men interviewed for this study could speak English only 3 women (30% of female respondents)[42] interviewed were able to communicate in English. This gap lends itself to a situation where women who are unable to speak English are relying on men to accompany them to hospitals and to act as translators.

Firstly, migrants who are unable to speak the primary language of their host country are often isolated and unable to interact with the host community. They face difficulty being

[40] Grant makers Health (2003) A Different World: Immigrant Access to Culturally Appropriate Health Care
[41] Respondents H,L,M,N,P,Q,R,S,T
[42] Respondents B,C,F

understood and are unable to clearly communicate the nature of their health problem. This means that many migrants are turned away from hospitals and clinics because they can not communicate. Often, they can only be treated for the superficial or most obvious problem because it is difficult for medical professionals to obtain any extra information in order to make a more comprehensive assessment of the health issue.

One male migrant reported having accompanied a female migrant to Coronation Hospital as the patient could not speak English. When the patient got to being seen by the doctor, the doctor wrote a referral letter to the clinic without examining the patient. When the translator queried this practice the doctor became angry and ignored what had been asked[43]. In this instance, it is difficult to establish whether the letter was a referral letter to the clinic or if the letter had been written to avoid having to treat the patient. Neither of the migrants were told what the letter was for. If the letter was a referral letter, this is a standard feature of the DHS and also affects the South African population.

4.1.1 Gender Roles and Social Norms

The language barrier is also played out in different situations. The Somali community has many strict ideas about gender roles and social norms. One such norm concerns the discussion of sex and reproductive issues between men and women.

The UJP tells us that 61% of the Somalis surveyed speak English. This percentage is not derived from an equal sample as the majority of Somali migrants who participated in the study were male. During my data collection, it came to my attention that the majority of Somali women do not speak English. Nine (90% of male respondents)[44] of the ten male Somali migrants could communicate in English, while only three (30% of female respondents)[45] of the ten female Somali migrants could communicate in English. This disparity might mean that women may need to rely on male interpreters to explain their health problems. In some instances a couple may rely on an interpreter to translate for them.

One male migrant reported accompanying a couple to Coronation Hospital to act as a translator[46]. The female migrant was seen in Obstetrics and Gynaecology.

[43] Interview with Respondent K, 17 November 2004
[44] Respondents H,L,M,N,P,Q,R,S,T
[45] Respondents B,C,F
[46] Interview with Respondent L, 18 January 2005

Many women are uncomfortable with divulging intimate details about their health to men who are often not their husbands. When being seen the doctor asked questions pertaining to the woman's reproductive functioning which the interpreter felt uncomfortable to translate. This meant that the interpreter was restricted in their capacity to explain the health problem to the doctor or to ask questions that may be thought of as inappropriate. Consequently, the doctor had very little information about the health issue and was limited in their capacity to provide a comprehensive assessment of the problem. This example indicates that the use of a translator does not always guarantee access to health care.

4.1.2 Compliance to treatment

The third element which needs to be explored is that of compliance to medication and treatment. If patients are requiring treatment for a problem that requires antibiotics, the rate of treatment success is small because patients may not understand what the medication is for and how it needs to be taken. Four of the twenty migrants interviewed (20%) reported that if Somalis were told something that did not understand they were more likely to pretend that they understood than to ask for clarity. In addition to this, three (30%) of the migrants complained that they had not received good treatment because they did not get given a lot of medicine.[47]

The inability of such migrants to understand and communicate in English may also mean that migrants may not always know their rights and where to go for help. In a health context, they may lack knowledge pertaining to where different categories of health problems are seen and the procedures involved when visiting the hospital or clinic.

Four migrants (20% of respondents)[48] reported that they or someone they knew had been accompanied by a translator to the hospital, but had been left on their own after being seen by the doctor because "they can't follow you around everywhere or wait with you the whole day…..they must go to work".[49] Migrants may wait in the wrong queue when collecting medicine because they do not understand the notices. This can mean that they do not receive their medicine and after having queued for a long time, have to move to the correct queue late in the day.

[47] Interview with Respondent D, 3 May 2004; Interview with Respondent E, 10 May 2004; Interview with Respondent H, 18 October 2005
[48] Interview with Respondent A, 22 January 2004; Interview with Respondent D, 3 May 2004; Interview with Respondent E, 10 May 2004;
[49] Interview with Respondent M, 8 July 2004

4.2 Lack of awareness of the rights of Forced Migrants

A 1998 survey conducted among South Africans by the Community Agency for Social Enquiry (CASE) suggests that negative attitudes towards migrants may be a part of a broader problem of human rights awareness. Only 55% of the respondents surveyed had heard of the Bill of Rights. Levels of education were seen to be consistently related to levels of knowledge. Only 18% had received any training or information about the Bill of Rights and 56% of people surveyed thought the rights guaranteed in the Constitution referred exclusively to South Africans[50]. This data shows that levels of knowledge about human rights vary significantly among different sectors of the population.

The lack of awareness among facility staff and medical professionals about rights guaranteed in the Constitution and the Refugees Act (130 of 1998) has contributed to the confusion which exists about the different categories of migrant groups and how they are understood in South African Law.

Part of the lack of knowledge about refugee rights could be due to a lack of familiarity with the various documents. The UJP tells us that 50.8% of the Somalis surveyed were recognised refugees, yet only 1.7% of them had a maroon identity document (ID). Without this document, it is difficult for refugees to demonstrate that they are recognised refugees and claim the rights they are entitled to in the Refugees Act.

The UJP data indicates that 6.8% of Somalis surveyed reported having had their documents confiscated or destroyed by various officials. The lack of knowledge concerning different forms of identification is exacerbated by this. It is such documents which distinguish refugees and asylum seekers from foreign migrants who are required to pay R1800.00 to receive health care.

Often times, whether or not a refugee gains access to appropriate treatment may be influenced by the health problem to be addressed. Four (40% of male respondents) of the male migrants who have had malaria themselves or knew of someone with malaria were admitted and treated satisfactorily.[51] Of the same group who had attended the casualty unit for an injury sustained through a fight, none had been given treatment

[50] Crush, J (2000) The Dark Side of Democracy: Migration, Xenophobia and Human Rights in South Africa cited in *International Migration* 38 (6) 103-123

[51] Interview with Respondent H, 18 October 2004; Interview with Respondent J, 30 October 2004; Interview with Respondent K, 17 November 2004; Interview with Respondent L, 24 November 2004

immediately.

This would suggest that rights operate differently at different times. Some of these differences could be attributed to the distinction between what is classified as an emergency as opposed to a non-critical complaint. However, there does not seem to be any clear consistent definition of what constitutes a medical emergency. In the same vein, 8 (40% of respondents) of the respondents interviewed raised the problem that ambulances often do not arrive when they call them. The respondents seemed to think that this was because "if you have a small pocket (pay less) you receive no respect." It is unclear whether this is an issue which specifically affects migrants or is also experienced by South African citizens using the hospital. Irrespective of who it affects, it is a violation of the right to emergency health care, as guaranteed in s27 (3) of the Constitution.

Literature suggests that sometimes migrants do not know their rights are being infringed.[52] This is contrary to what I observed while completing my data collection. It seemed that many migrants did not know the limits placed on rights. Almost all the migrants interviewed (75% of respondents) spoke of their right to health care as a fundamental human right[53]. Human Rights are described as universal, higher order rights.[54] This would suggest that they should be afforded authority and consideration, in a way that is different and more superior to rights guaranteed in national law. While health care is recognised as a fundamental human right, states may acknowledge this right by signing international covenants and conventions. But this recognition is not always accompanied by the inclusion of such human rights into national legislation.

This distinction is one which is often not clearly understood by forced migrants. Many migrants are inclined to explain their being unable to receive a particular level of care as a violation of their human rights, without considering the bounds and limits of the Refugees Act. What is explained as a denial of access may be the practice of health care service delivery (within the means of the state) which is offered to the entire population, whether or not they are South African.

[52] Duckett, Margaret (2001) Migrants Right to Health Best Practice Collection. Paper prepared for UNAIDS and International Organisation of Migration (IOM)
[53] Respondents B, D, E,F, G, H, K,L,M, N, O, P, R
[54] (2001) American Journal of Public Health The Challenge and Place of International Human Rights in Public Health, Editorials v 91 (12) 1922-1924

One male migrant remarked that "Refugees only have Human Rights but South Africans have their own rights."[55] Given that South Africans, refugees and asylum seekers all share the same right to have access to health care, the comment may refer to the fact that there is often a discrepancy between rights guaranteed in theory and rights delivered in practice. This difference can also be observed in the discrepancy between what International Conventions say and what is provided for in the Refugees Act. Respondents who referred to their rights in terms of the Refugees Act tended to be those with refugee status.

Three (30% of female respondents) of the female migrants interviewed stated that they felt that staff working in medical facilities need to know and understand what happened in Somalia in order to provide good health care[56]. There seemed to be an impression among Somali migrants that the violence and destruction they have fled from must be taken into account when determining the level of health care forced migrants should be able to access.

This perception may imply that forced migrants believe that should have more extensive rights (than they have now) to health care, because of their vulnerability. Perceptions such as these have contributed to the literature which focuses specifically on demonstrating the undue discrimination faced by refugees as a catalyst for recognising the special nature of the refugee cause and their right to be treated differently. Such advocacy may refer to refugees being able to access socio-economic rights which form part of the Refugees Act or alternatively may refer to refugees being given better quality health care because of their vulnerable circumstances.

4.3 Xenophobia and Racism

> "When non-nationals are deprived of opportunities to be healthy, this not only endangers their own health, but also promotes denial and discrimination. It jeopardizes public health efforts, in particular prevention efforts, thereby threatening the public's health"[57]

[55] Interview with Respondent H 18 October 2004
[56] Interview with Respondent B, 15 February 2004 (2); Respondent N, 16 August 2004, Respondent D, 3 May 2004.
[57] Gilmore N (1998) Human Rights Issues and Migration, Presentation at the 12th World Aids Conference, Geneva, Switzerland (July 1998)

Many migrants reported experiences of name-calling and exclusion when trying to use health services. This was perpetrated by people within the health system and members of the public using the health facility. Some of the discrimination was overt and directed at the migrants, but a large part also took the form of discussions among staff.

This practice either took the form of physical discrimination such as exacting a bribe or ignoring someone waiting in the queue to be seen. Migrants reported being ignored and made to wait until the last person had been treated and in some other instances being told to return for treatment the following day. One migrant reported going to the hospital on the scheduled date for her ante-natal check-up, being ignored and being told at the end of the day to return the following week.[58]

Some practices of discrimination and racism take the form of name-calling and racial slurs shared between staff members, but are often overheard by migrants. Four of the six female migrants who did not understand English shared that even though they did not understand what was being said, they knew they were being spoken of in a derogatory way. All of the migrants interviewed (100%) identified racism and xenophobia being a problem and had witnessed or been a victim of such name-calling and prejudice.

One female migrant reported being told by a midwife while she was in labour that "You are not paying me so I am not going to cut you." This experience relates directly to Somali women requiring a Caesarean delivery because of the practice of female circumcision.[59] A second experience which is related to the above was that while giving birth, the attending midwife was calling the other staff on duty to come and see what the vagina of a woman who has undergone female circumcision looks like.[60]

Despite these incidents of prejudice and discrimination, it is important to note that many migrants have had positive experiences when seeking health care. One migrant mentioned getting a lot of care and attention when she was hospitalised at Helen Joseph Hospital soon after arriving in South Africa[61]. Three of the female migrants interviewed (30% of female respondents) indicated that they had received good treatment at Coronation Hospital.[62]

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[58] Op Cit
[59] Interview with Respondent N, 16 August 2004.
[60] ibid
[61] Interview with Respondent A, 22 January 2004
[62] Interview with Respondent A, 22 January 2004; Interview with Respondent E, 10 May 2004; Interview with Respondent G, 9 June 2004

Similarly, one elderly male refugee who is paralysed said that he had never experienced any difficulty when seeking care at the Mayfair Clinic. He shared that whenever he goes to the clinic the nurses fetch him at the door and push him through the clinic in his wheelchair when he is ready to be seen by the nurse[63]. He also reported that the most helpful nurse was the Operations Manager. This case also draws our attention to the fact that health personnel may be less likely to practice overt xenophobic behaviour such as ignoring a disabled person because they are a forced migrant, than a less obvious behaviour such as ignoring or verbally insulting someone who does not speak English. Despite the elderly male refugee receiving very good service from the Operations Manager, there is also a female migrant who opened a case against the same nurse for discrimination and publicly humiliating her. This instance illustrates clearly the wide disparities in the perception and experiences of Somali migrants. It also highlights the importance of recognising that stereotypical attitudes and labels can not be attributed to all health personnel, and that xenophobia and prejudice are not the sole variables which determine and motivate the actions of health personnel.

Two of the migrants interviewed (20% of respondents)[64] said that they thought the quality of treatment you received was influenced by how long you had been here. If you "came before there were so many Somalis then you are treated OK[65] because people know you and your file is old."

4.4 User Fees

Different categories of people are charged varying amounts to utilise public hospitals. These amounts vary based on ones income and ones residence status. User fees tend to be set at provincial level and should apply uniformly to all provincial facilities in Gauteng. Despite this, there are large discrepancies in what forced migrants have been charged both at the same facility and between facilities in Johannesburg.

Fees for patients using health care services at a public hospital can vary according to the level of care being sought. In some hospitals a slightly higher fee is charged than that charged for outpatient services. There should be no more than a R30.00 to R50.00

[63] Interview with Respondent J, 25 October 2004
[64] Respondent F, J
[65] Respondent F

difference in the amount charged for different categories of service at a public facility. Forced migrants are being charged amounts varying from R20.00 to R1800.00. The fee of R1800.00 may refer to foreign patients who are not South African citizens, have no medical insurance and are not a refugee or asylum seeker. At no point should refugees or asylum seekers be required to pay this fee.

Until mid 2004, any forced migrant who was awaiting the outcome of their application for refugee status was classified as an asylum seeker and would be charged the same fees as those paid by any foreign migrant. During the period of the study, regulations changed and asylum seekers are now entitled to the same health services as recognised refugees. Although these rights are now uniform, forced migrants are still being asked to pay fees that are both different to South Africans and range between R20.00 and R1800.00.

The practice of turning people away and charging migrants' high fees for access has often been attributed to a lack of awareness of the rights of forced migrants. The location of posters of the various kinds of identity documents that are posted throughout Coronation Hospital would suggest that the practice of exclusion can not be wholly attributed to a lack of knowledge. Some of the behaviours and the practice of exacting bribes have been attributed to xenophobia and racism.

The applicability of these fees also varies based upon the level of care being sought. All people in South Africa are entitled access to emergency care, irrespective of their residence status. Despite this, confusion exists about what can be classified as emergency care. One female Somali forced migrant reported having gone to the Johannesburg Hospital once she was in labour and being told she would not be admitted until she had paid R1800.00.[66]

The practice of exacting bribes has also included clerks and guards telling forced migrants they will only be allowed in to the hospital if they give them chips, cold drink or a chocolate[67].Eleven (55% of respondents) of the migrants interviewed reported experiencing this[68]. Nine of the migrants admitted to complying with the request. One male migrant reported being told by a guard that he would only be allowed into the ward to visit someone if he gave him a chocolate, despite the migrant abiding with regulated

[66] Interview with Respondent M 8 July 2004.
[67] Interview with Respondent E, 10 May 2004; Respondent P 24 November 2004
[68] Interview with Respondent A,B,D,E,G,I,L,N,O,P,R

visiting hours.[69] Another migrant reported that the request for cold drinks, chips or chocolates is understood to imply a request for money and that if migrants did not provide money or the food requested, the guard was unlikely to offer any help to the migrant.[70]

4.5 Difficulties negotiating the structure of the health care system

One of the major barriers faced by forced migrants when seeking health care is a lack of knowledge about how the system functions and where to go for help.[71] This has direct implications for how migrants meet their health needs and the way the health system is utilised.

4.5.1 Referral System

One of the central tasks of the DHS is to reduce the care burden placed on hospitals, through helping clinics to function more effectively. This has required the creation of a well-functioning referral system, thereby ensuring that minor complaints which can be attended to by a nurse are seen in clinics and that hospitals are used for secondary care. This should mean that no person will be able to use the hospital without being able to demonstrate they have attended a clinic first. This system relies upon the use of referral letters between facilities. In some instances, this can mean that patients who attend the hospital without a letter are sent back to the clinic. It could even happen that a doctor may send a patient back despite having a referral letter, because they think the problem could be managed by a nurse.

There is a common perception that the treatment offered at hospitals will be far superior to that offered at a clinic. This has resulted in many people using the hospital as their first resource for treatment. A lack of awareness among migrants about the different health facilities and services available may mean that migrants will go to the hospital for any health problem, without having gone to the clinic first. Two of the female migrants (20% of female respondents) reported being sent back to the clinic without being seen at the hospital[72].

[69] Interview with Respondent P, 24 November 2004.
[70] Interview with Respondent K, 17 November 2004
[71] Ascoly N, van Halsema I & Keyser L (2001) Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands *Journal of Refugee Studies* 14 (4) 371-393
[72] Interview with Respondent I, 25 October 2004; Interview with Respondent N, 16 August 2004

4.5.2 Record keeping

The second obstacle identified by migrants is the record keeping system for child health services offered in clinics. Child Health Services work on a system of 'clinic cards' which are kept by caregivers, and patient files that are stored at the facility which the child attends for growth monitoring and immunisation. If a patient is not in possession of a clinic card, they face being sent back to where the child was born to retrieve these records. In the interim, the child can not be seen until the card is located or if necessary, re-issued.

The nature of migration is such that people are always moving and are often not based in the same place for any period of time. The movement may take place within a city, between cities or between countries. There is great potential for documents to get lost or destroyed. The study revealed that the two largest Somali migrant communities in South Africa are based in Cape Town and Johannesburg, with much movement between both cities. One female migrant reported having come to Johannesburg from Cape Town, and upon taking her child to a clinic was told to return to the place where the child was born (Cape Town) and that she was unable to do this because she had no money.[73]

A second incident which was told to me in the very early stages of the study, was of a Ugandan woman who had attended a clinic in Johannesburg and upon trying to explain that she had lost the child's health records, was told she must "go back to Uganda and fetch them."[74]

4.5.3 Expectations of health service levels

In relating their experiences of inadequate treatment, migrants give the impression that they believe that the greater the amount of time a doctor spends with a patient and the more medicine they dispense the better is the treatment being provided.

Three female (30% of female respondents) migrants reported that not being given enough medicine was a major constraint to access. One of the migrants reported that they had only been given four items of medicine and that if one can pay for private care

[73] Interview with Respondent E 10 May 2004
[74] Interview with Respondent B (2) 15 February 2004

"you get lots of things, lots of questions and lots of treatment because you pay for it".[75] However, migrants are often employed in sectors where medical aid is not available and making use of private health care is unaffordable.[76] This can mean that migrants have little choice other than to make use of public facilities, irrespective of the quality of treatment available. In some instances, patients were only given Paracetamol.[77] This drug does not require a prescription and is used predominantly as an over-the-counter analgesic.

Secondly, migrants felt they had not been properly examined by doctors. One female migrant remarked that she should have been properly examined and treated because she had just arrived from Somalia. Instead she was "treated like she had a small problem and given no dignity or respect"[78] The same migrant felt that if she had been a citizen she would have been examined and at least asked what was wrong, instead she was sent away without being seen. She also said that, unlike in South Africa, when there was peace in Somalia she was treated with dignity and respect.

The presence of a trusting relationship between doctor and patient is especially important given the cultural and religious beliefs which govern behaviour in the Somali community. Trust is often only developed after a patient has met with a doctor over some time. Initially, migrants may feel uncertain about the agenda or the behaviour of the doctor. These perceptions may influence the information which is shared with medical practitioners and the success of treatment.

Two (20% of female respondents) of the female migrants found that being seen by different medical staff was a major obstacle to accessing health services. This made it difficult to establish a relationship between the medical practitioner and the patient, thereby constraining access.[79]

[75] Interview with Respondent M, 8 July 2004
[76] Kullgren, J T (2003) Restrictions on Undocumented Migrants' Access to Health Services: The Public Health Implications of Welfare Reform *American Journal of Public Health* 93 (10) 1630-1633
[77] Interview with Respondent D 3 May 2004; Interview with Respondent E, 10 May 2004; Interview with Respondent N, 16 August 2004
[78] ibid
[79] Ascoly N, van Halsema I & Keyser L (2001) Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands *Journal of Refugee Studies* 14 (4) 371-393

5. PERCEPTIONS OF HEALTH PERSONNEL OF ACCESS CONSTRAINTS AND EFFORTS IF ANY TO IMPROVE ACCESS

The previous chapter has documented in detail the constraints faced by Somali forced migrants when trying to access health care services. The evidence is based largely on the recorded perceptions of these migrants given their experiences when trying to access health care. This chapter looks at the same issue from a different perspective. It details how health care workers who are responsible in one way or another for determining access perceive the access constraints of Somali forced migrants. The analysis will show that health care workers confirm many of the perceptions of access constraints relayed by the surveyed population. However, there are also notable differences in perception which raise important questions about how valid migrants' perceptions of disadvantage are in the context.

Each of the constraints identified by health personnel will be discussed individually. The chapter will seek to identify areas of similarities and contrast between migrants and health workers and will evaluate the agreements and disagreements in evidence. The chapter analyses whether doctors' perceptions are an important corrective to the experiences of migrants or whether the health care personnel are just another example of the attitudes and misunderstandings that underpin access constraints experienced by migrants.

5.1 Language and Communication

As noted in the previous chapter, the inability of forced migrants to communicate in English is a major barrier to migrants accessing health care. Migrants suggested that this barrier impacts upon health treatment in different ways. Health personnel interviewed confirmed this view, and were able to give clarity on the varied ways that language difficulties do impose constraints.

Firstly, it may mean that health personnel are unable to obtain a complete patient history because women may feel uncomfortable divulging such information. Nine of the ten health professionals interviewed (90% of health personnel) cited this as a barrier to delivering high quality care. In an attempt to overcome this, the Obstetrics and

Gynaecology Department said that they had considered obtaining a female Somali migrant to translate for doctors in order to overcome some of these difficulties.[80] In the first part, doctors would be able to understand patients better. It was also hoped that using a female translator would assist in overcoming some of the cultural barriers discussed above. The unit was hoping to use a translator on certain days of the week and then to organise the ante-natal bookings around this. However, the Head of Obstetrics and Gynaecology said they could not find a volunteer translator and that the unit did not have the money to pay a translator.

Another difficulty doctor's face when treating Somalis who cannot understand English is how to conduct health education and health promotion. Six of the doctors (60% of health personnel) interviewed cited the inability to communicate as a major barrier to providing health education and information to Somali forced migrants.[81] Health problems such as malnutrition, hypertension and diabetes can be managed through making basic changes to ones lifestyle. This requires understanding what causes and aggravates particular health problems and how to avoid such behaviours. If patients were able to participate in health education and modify their lifestyle accordingly, it would alleviate some of the burden on formal, secondary care traditionally delivered at hospitals. Where doctors can not interact with their patients without the assistance of a translator, it becomes very difficult to use health promotion and health education activities with patients.

Eight of 20 migrants (40% of respondents) interviewed mentioned that they had experienced or heard of health personnel not allowing translators into the consultation room for reasons of confidentiality. All of the doctors interviewed stated that they had never heard of this practice or behaved in such a way. It remains interesting that more than one migrant mentioned having experienced this at Coronation Hospital, yet the doctors were not aware of this occurrence. Doctors who may have behaved in such a way might also be reluctant to admit this because of the potential consequences.

Doctors also spoke of the frustration that many migrants express when they do not understand what is being said. Four (40% of respondents) of the doctors interviewed all shared that they have had prior experiences of Somalis becoming quite aggressive and rude when they have been unable to communicate.[82] Seven (35% of respondents) of the

[80] Interview with Respondent 9, 8 February 2005
[81] Respondents 1,2,3,4,5,6
[82] Respondents 1,3,5,6,

migrants interviewed confirmed that often Somali people become frustrated at their inability to communicate.[83] This behaviour has contributed to the ongoing perceptions of forced migrants being rude and difficult to treat. It is further aggravated by the fact that the hospital setting can often require people to wait for long periods before being seen. This is a feature of the public health system which all patients, whether or not they are South African, are faced with when seeking care at hospitals.

Some of the barriers which impact upon the capacity of medical professionals to provide health care to Somali forced migrants are a result of forced migrants not always having a clear understanding of the health system itself. This lack of knowledge may be due to a language barrier. It could also be due to a lack of understanding about how the system works. This can mean that migrants may attribute any negative experiences they encounter when trying to access health care as being due to their identity as forced migrant.

Two (20% of respondents) of the 10 doctors interviewed felt that issues facing doctors when communicating with migrants had less to do with a language barrier, and more to do with cultural beliefs and ideas.[84] Different cultural understandings of health and disease also impact upon the ability of medical professionals to understand and treat the particular health problem brought to them. Many times, access to the health system may also be influenced by cultural or political reasons that South Africans are not familiar with.[85] Duckett (2001) uses the term *ethnic distance* to describe these differences. Three of the doctors (30% of health personnel) interviewed who work in Paediatrics at the hospital mentioned this issue.[86] This study confirms the findings of a similar study conducted with different levels of medical personnel at a major hospital in Copenhagen, Denmark.[87]

The impact of gender roles and social norms which exist in the Somali community was identified by migrants as a barrier to access. Health personnel also recognised this as an

[83] Interview with Respondent A, 24 January 2004; Interview with Respondent B, 4 May 2004 (3); Interview with Respondent C, 22 February 2004; Interview with Respondent H, 18 October 2004; Interview with Respondent K, 17 November 2004; Interview with Respondent P, 24 November 2004; Interview with Respondent T, 18 January 2005;
[84] Interview with Respondent 8, 3 February 2005; Interview with Respondent 9, 8 February 2005.
[85] Duckett, Margaret (2001) Migrants Right to Health Best Practice Collection. Paper prepared for UNAIDS and International Organisation of Migration (IOM).
[86] Interview with Respondent 5, 24 December 2003; Interview with Respondent 8, 3 February 2005, Interview with Respondent 6, 27 January 2005
[87] Michaelsen, J J (et al) (2004) Health professionals' knowledge, attitudes, and experiences in relation to immigrant patients: a questionnaire study at a Danish Hospital *Scandinavian Journal of Public Health* 32 287-295

obstacle to providing quality treatment and care to migrants. The doctors explained these barriers as being due to beliefs that are rooted in expectations and ideas about the appropriate way women should behave and how they should interact with broader society. These beliefs are reflected in the fact that only a minority of women can speak English, and that very few women work. On more than one occasion during my field work, I was unable to enter and speak with female Somali migrants because their husbands were not at home. These gender roles can impact quite strongly upon the way female migrants interact with health personnel, many of whom are male.

Six doctors (60% of respondents) also mentioned the fact that women were unforthcoming and reluctant to make eye contact with health professionals.[88] Such behaviour can make it difficult to develop a trusting relationship between the health care provider and patient. As a result, women may be reluctant to communicate directly with health personnel. This limits the interaction between health personnel and patient to one of questions and answers, where medical practitioners will obtain very limited information about the problem. This form of interaction also lends it self to women merely agreeing with medical staff whether or not they understand what is being said. Four male Somali migrants (40% of male respondents) raised this behaviour as a major obstacle to access for women. Secondly, this barrier may cause women to delay in seeking treatment because they feel uncomfortable explaining intimate health problems.[89]

But, Somali women are not only attending the Obstetric & Gynaecology Unit of Coronation Hospital. Many of the women interviewed have also brought their children to the Paediatrics Department. The reticence of women and their reluctance to communicate was reported by two (20% of respondents) senior doctors working in the Paediatrics Department.[90]

This could mean that such behaviour is not restricted to women seeking reproductive health care and may reflect a broader cultural understanding of the way women should conduct themselves in any setting. I noticed this behaviour myself while completing my fieldwork. Despite this, these behaviours could also be attributed to a general feeling of vulnerability because of ones status as a foreign migrant.

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[88] Interview with Respondent 2, 31 December 2003; Interview with Respondent 4, 31 December 2003, Interview with Respondent 5, 24 December 2003, Interview with Respondent 6, 27 January 2004, Interview with Respondent 8, 3 February 2005; Interview with Respondent 9, 8 February 2005
[89] Interview with Respondent H, 18 October 2004; Interview with Respondent K, 17 November 2004; Interview with Respondent L, 24 November 2004; Interview with Respondent O, 24 November 2004
[90] Interview with Respondent 7, December 2003; Interview with Respondent 8, 3 February 2005

5.2 Attitudes and behaviour of health personnel

While this study focussed upon doctors and their interaction with foreign migrants, it soon became clear that the conduct of health care workers was equally a matter of concern for Somali migrants. Migrants frequently complained of verbal abuse and discrimination perpetrated by midwives and nurses. Six female migrants (60% of female respondents) stated that they had experienced specific difficulties when interacting with health care workers. These difficulties included being ignored, being publicly humiliated while waiting to be seen, and being turned away.[91]

When doctors were asked about the behaviour of nurses and midwives, both the head of Paediatrics and Obstetrics and Gynaecology acknowledged that nurses and midwives were perceived to be very rude to patients. The head of Paediatrics admitted having seen nurses speak about migrants in a derogatory way. Despite this, the majority of health personnel (80%) still believed that migrants were more likely to seek care at a hospital because clinic staff are believed to be more xenophobic than hospital staff.[92]

Complaints about doctors were less frequent. Only two migrants (10% of respondents) stated that they had negative experiences with doctors[93]. All of the doctors interviewed stated that they approached foreign migrants in the same way as any other patient, "a sick person needing help – irrespective of who they are and where they come from." The same doctor went on to say that he could not penalise children for being foreign because "children are dependent on their parents and can not be held accountable for the actions of their parents."[94] This perspective resonates with the experience of the majority (70% of doctors) who reported viewing their commitment to the Hippocratic Oath and the Patients Rights Charter as more important than policing whether migrants were entitled to access health services at the hospital[95].

The head of Obstetrics and Gynaecology went on to say that it was not the role of medical professionals to determine access. He felt it the responsibility of administrators to determine and control access to services because once migrants were past the front, they were unlikely to be refused treatment. This sentiment concurs with the general perception that it is not the responsibility of health personnel to manage access and that

[91] Interview with Respondent A, D, E, G, N & O
[92] Interview with Respondent 2,3,4,5,6,7,8, 9
[93] Interview with Respondent C, 22 February 2004
[94] Interview with Respondent 8, 3 February 2005
[95] Interview with Respondent 2,3,5,6,7,8,9.

administrators should be more rigorous about who is given access. He admitted to feeling that there were foreign migrants who were using the hospital under false pretences.[96]

The lack of knowledge and clarity among medical professionals as to the different categories of migrants and their rights and entitlements in part explains this. Nine of the ten (90% of respondents) health personnel interviewed were unclear about the different kinds of migrants.[97] Once migrants have gained access, there is little reason for medical staff to know the difference between these categories. However, the lack of clarity about the different migrant categories and the rights of forced migrants to health care contributes to the perception that many so called illegal immigrants are using the system under false pretences. This impression is often generalised to those forced migrants who are legitimately entitled to access health care services.

Only two doctors (20% of respondents) identified a lack of documents as a barrier to accessing health care. One of the two stated that migrants were likely to obtain false papers in order to gain access. In contrast to this perception, nine of the migrants interviewed (45% of respondents)[98] reported that not having documents was a major barrier to accessing health care.[99] This view is confirmed by the UJP where 33.9% of Somali migrants interviewed said that not having documents prevented them from being able to access health care.

The difference in perception of doctors and the experience of migrants could be explained by the fact that doctors work outside of the administration system. Documents are required upon opening a file at the administration desk. It is at this point that migrants are most likely to be denied access to services because they do not have documents. Once migrants have opened or collected their file it is unlikely they will be asked for their documents again.

The same doctor reported that Coronation Hospital makes arrangements for people who are desperate and need health care. She went on to say that the hospital will arrange that patients who can not pay will be seen if they are very sick and that doctors would fight

[96] Interview with Respondent 9, 8 February 2005.
[97] Interview with Respondents 1,2,3,4,6,7,8,9,10
[98] Interview with Respondent A, C, D, E, G, L, I, O, T
[99] During the period of research, the rights of asylum seekers to health care changed. Prior to this, having a pending application for status (document stating an application for refugee status has been lodged) meant asylum seekers had no legal right to access any health care, other than emergency treatment.

for migrants to be given basic medication, irrespective of whether or not they are South African.[100] There are mixed responses among doctors as to whether Coronation Hospital has taken active steps to accommodate migrants. Both the head of Paediatrics and Obstetrics and Gynaecology felt that the facility has not taken any active steps to accommodate them. Five of the other doctors interviewed (50% of respondents) believed that the hospital does take active steps to accommodate migrants.[101]

A lack of knowledge on the part of medical staff as to the rights of migrants has also been used as a way of explaining migrants being turned away from facilities or being made to pay high user fees. While doctors may not be directly responsible for either of these behaviours, this occurrence indicates the multiple points at which access can be denied.

Education and training have been used as a variable to explain the difference in attitudes among doctors and nurses. A study conducted in a large public hospital in Copenhagen establishes a link between level of education and attitudes to immigrants. The study found that doctors had more positive attitudes towards immigrants than nurses because their higher education provided a more "fundamental safety feeling", or a feeling of not being in a competitive situation with migrants.[102] While the situation in South Africa may be slightly different, it has been broadly recognised that doctors tend to be less xenophobic than nurses and midwives.

The xenophobic attitude of nurses and midwives has been attributed to stressful working conditions and the health system being under-resourced.[103] The Obstetrics and Gynaecology unit at Coronation Hospital is faced with severe resource constraints. At the time of the study, the unit had only two nurses. Nurses and midwives also have more direct contact with forced migrants and in the context of high numbers of patients requiring care and treatment, forced migrants may easily become the target of antagonism and resistance. Two doctors (20% of respondents) also sought to explain the discriminatory behaviour of nurses and midwives as a consequence of staff being demoralized.[104]

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[100] Interview with Respondent 6, 27 January 2004
[101] Interview with Respondent 2,3,4, 5,6
[102] Michaelsen, J J (et al) (2004) Health professionals' knowledge, attitudes, and experiences in relation to immigrant patients: a questionnaire study at a Danish Hospital *Scandinavian Journal of Public Health* 32 287-295
[103] Interview with Respondent 6, 27 January 2004; Interview with Respondent 9, 8 February 2005.
[104] Interview with Respondent 6, 27 January 2004

Coronation Hospital expects to deliver 8000 babies this year. Due to staff and resource shortages, the Obstetrics and Gynaecology unit is only able to see twenty women per day for first time antenatal visits. A consequence of this is that any woman who arrives after 06h30 am and is booked for an antenatal visit is unlikely to be seen. This can act as a major barrier for migrants who are unfamiliar with the way the hospital system works. Doctors attribute this practice to resource constraints rather than an intentional attempt to exclude migrants.

However, female migrants did report that despite being on time for antenatal visits, some were ignored and made to wait until all the other women had been seen. In one instance after being made to wait a female migrant was told to return the following day. One female Somali migrant who before fleeing Somalia, practiced as a nurse in Mogadishu reported conducting the basic care herself after being made to wait until the last person being seen, despite being on time.[105] This tells us that irrespective of resource constraints which affect all women using antenatal services at Coronation Hospital, there remain instances of prejudice and discrimination that female migrants experience from midwives.

It was acknowledged by the Head Doctor in the Obstetrics and Gynaecology unit that the hospital itself continues to be faced with many complaints from women (South Africans and foreign migrants) about the behaviour and treatment received from midwives in the unit. Twelve (60% of respondents) of the migrants interviewed stated that Somali migrants were unlikely to complain about the poor treatment they have experienced. Respondents attributed this to their inability to speak English and not knowing who to complain to. One male migrant went on to say that migrants were also unlikely to complain because they had no trust in the system in Somalia and did not believe that complaining would help.[106]

Only two of the migrants interviewed had reported the poor treatment they received at a public health facility to someone in authority. One female migrant[107] told how she had reported the poor treatment she had received in the Obstetrics and Gynaecology unit at Coronation Hospital to the Superintendent. The other migrant who had complained was a male migrant who had accompanied a patient to Helen Joseph. The patient required emergency treatment and was made to wait by a doctor.

[105] Interview with Respondent B, 24 January 2004 (1)
[106] Interview with Respondent L, 24 November 2004.
[107] Interview with Respondent B, 4 May 2004 (3).

The other migrants present while the story was being told to me, knew immediately which doctor he was referring to. This may suggest that there are particular doctors or midwives who are known by Somali migrants to be especially xenophobic. In both instances despite complaining, the two migrants were not aware if any action had been taken. One of the female migrants interviewed went on to say "Even if you complain, you don't get rights."[108]

A third incident of discrimination and humiliation was experienced by a female migrant at Mayfair Clinic. The incident had resulted in the woman reporting the behaviour to the police and opening a case against the offending nurse.[109] I was unable to meet with the female migrant. The reason given was that her husband had told her not to speak to anyone about the matter. Subsequently, I approached the Mayfair clinic requesting to interview a clerk and two nurses for this study. I was told that they were not prepared to allow me to interview staff without obtaining permission from the regional manager. This procedure was quite different to that I knew of in other clinics. I learnt soon afterwards that the case had been lodged against the nurse in the month prior to my request.

5.3 Influence of culture on health-seeking behaviour

At the start of the study, many doctors thought that the reason Somali women use the Obstetrics and Gynaecology unit at Coronation Hospital was because there were female Muslim obstetricians or gynaecologists. A study conducted in the United Kingdom with female Somali migrants found that the presence of doctors who shared similar cultural and religious backgrounds in a particular clinic was an important factor which influenced their choice to attend the clinic being studied.[110] This study did not confirm such findings. All of the female migrants interviewed indicated that the presence of Muslim obstetricians or gynaecologists was not a reason for using Coronation Hospital. They said the primary reason they used the hospital was because it was closest to where they live.

Four of the doctors interviewed (40% of respondents) stated that some female Somali migrants are unable to consent to treatment or reproductive procedures without the

[108] Interview with Respondent C, 22 February 2004.
[109] Interview with Respondent B, 12 November 2004 (4)
[110] Messele, A (2001) Access to health services for refugees and asylum seekers : Experiences and views of women refugees and asylum seekers living in Redbridge and Waltham Forest – report of a focus group Faculty of Health, South Bank University

permission of their husbands.[111] None of the migrants interviewed said that they had never heard of this, and that it was more likely to be the reason given for women refusing some gynaecological procedures because they felt uncomfortable.

One male migrant remarked that "there are some Somali women who are married with children and their husband has never seen their naked body."[112] This experience confirms the strong cultural ideas about sex and sexuality, and how these constrain the ability of doctors to provide high quality comprehensive treatment to forced migrants.

While four of the doctors (40% of respondents) agreed that female migrants requiring permission from their husbands was a major barrier[113], the head of Obstetrics and Gynaecology went on to say that rather than acting as a constraint, doctors working in the unit are concerned about ensuring the agreement of husbands to the proposed procedure or treatment, for the reason that "they know what could happen at home….if the husband did not know and understand the implications of the required treatment." This approach is in sharp contrast to the perception that female migrants needing their husbands permission constrains the ability of doctors to provide treatment. The approach of ensuring the understanding and consent of a husband seems to be a step which is preventive and part of an attitude of well-being and concern to the plight of migrants and the strict cultural beliefs that influence the capacity of women to exercise their own free will.

Two doctors mentioned (20% of respondents) that the strong emphasis upon child-bearing within the Somali community significantly influences the choices made by female Somali migrants. The doctors stated that women are expected to be able to fall pregnant, and an attitude which sees women as superfluous and useless if they can not conceive. [114]

In relation to this, Somali women are also requesting treatment for infertility at the Obstetrics and Gynaecology unit. Constraints on resources have come to mean that the hospital does not provide fertility treatment on a regular basis and that there are long waiting lists for such treatment.

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[111] Interview with Respondent 1, 20 December 2003; Interview with Respondent 3, 18 December 2003; Interview with Respondent 4, 31 December 2003; Interview with Respondent 5, 24 December 2003.
[112] Op Cit
[113] Interview with Respondent 1, 20 December 2003; Interview with Respondent 2; 31 December 2003; Interview with Respondent 4, 31 December 2003; Interview with Respondent 5, 24 December 2003
[114]Interview with Respondent 1, 20 December 2003; Interview with Respondent 9, 8 February 2005.

The head of Obstetrics and Gynaecology suggested that migrants may perceive the delay in receiving treatment as being due to their status as a forced migrant.

5.4 Attitudes of South African citizens

"South Africans not only hold negative attitudes towards foreigners, they also have a readily accessible set of stereotypes with which to justify or rationalize their negative attitudes"[115]

Six of ten doctors (60% of respondents) interviewed mentioned that Somali forced migrants also face discrimination and xenophobia from South African citizens using the hospital.[116] Thirteen of the migrants (65% of respondents) confirmed having experienced negative attitudes and xenophobic behaviour from fellow South African patients.[117] This xenophobic behaviour is particularly prevalent in Obstetrics and Gynaecology, where doctors report that South African women seem to feel that in the context of severe resource constraints, "forced migrants are taking up scarce resources […] and should not be receiving care when so many South African women have to wait long periods of time before being seen."[118] This attitude has also at times included the accusation that immigrants are stealing jobs.

An article in Human Rights Watch records that "South Africans perceive foreigners – especially, almost exclusively – black foreigners – as a direct threat to their future economic well-being and as responsible for the troubling rise in violent crime in South Africa"[119] It is such perceptions which further constrain the capacity of migrants to gain access to their guaranteed socio-economic rights and to integrate into broader society. Such perceptions have significant implications for the ability of self-settled forced migrants to integrate into the host community.

[115] Mattes (et al) (1999) Still Waiting for the Barbarians: South African Attitudes to Immigrants and Immigration *Southern African Migration Project Policy Paper no 14* Cape Town and Kingston
[116] Interview with Respondent 1,3,5,7,8,9
[117] Interview with Respondent A, B, C, E,G,H, I, K,M,N, P, R, T
[118] Interview with Respondent 9, 8 February 2005; Interview with Respondent N, 16 August 2004
[119] Human Rights Watch (1998) Prohibited Person: Abuse of Undocumented Migrants, Asylum Seekers and Refugees in South Africa *Human Rights Watch* New York

5.5 Interactions with other public health facilities in Johannesburg

It is interesting that despite all of these constraints, the complex of Helen Joseph and Coronation Hospital are perceived by Non-Governmental Organisations (NGOs) working with forced migrants, to be less discriminatory and more open to forced migrants than Johannesburg Hospital.[120] Forced Migrants are being advised by NGOs to seek care at Coronation and Helen Joseph hospitals rather than Johannesburg Hospital. Despite this, eight Somali forced migrants (40% of respondents) report having been turned away or being made to pay exorbitant entry fees irrespective of their rights to health care stipulated in the Refugees Act.[121]

Recognised refugees have reported being made to pay R1800.00 when attempting to seek care at Johannesburg Hospital. In another instance, a doctor working at Coronation Hospital spoke of some patients being asked by midwives at Johannesburg Hospital to pay R20 000 upfront to receive ante natal care.[122] This is a blatantly illegal practice. It is also in the context of a government policy which stipulates that all pregnant women and children under the age of six years are entitled to free health care.

Both the head of Paediatrics and Obstetrics and Gynaecology at Coronation Hospital suspected that migrants had to pay bribes to clerks or guards to gain access to health facilities in Johannesburg. Eleven (55% of respondents) migrants confirmed being asked for a bribe when attempting to use hospitals in Johannesburg.[123] The government policy provides for free health care to all pregnant women and children under the age of six years. This should mean that forced migrants should not be charged when bringing young children to the hospital. The extent of their interaction with administrators and clerks should be to obtain a stamp from the clerk or to collect their file. No money should be involved.

However 7 female migrants (70% of female respondents)[124] reported being asked for a bribe to access the hospital. One of the three migrants reported having brought her child to casualty late at night and being asked for a chocolate and a packet of chips from the guard before he would let her in. This instance is itself violates the Constitutional

[120] Interview with staff member of Jesuit Refugee Services, Informal discussion in Forced Migration Working Group, Wits University, August 2004
[121] Interview with Respondent A,D,E,F,G, I, K, T
[122] Interview with Respondent 9, 8 February 2005.
[123] Interview with Respondent A, B,E,G,I,L,N,O,P,R, T
[124] Interview with Respondents A,B,D,E,I,N,O

guarantee contained in s27 (3). This clause stipulates clearly that "no one may be refused emergency medical treatment."

Though this form of bribery is not directly perpetrated by health personnel, it has direct implications for the ability of migrants to access health services. Nine migrants (45 % of respondents) admitted to complying with the request for a bribe.[125]

Both doctors and migrants were able to record numerous instances of Johannesburg Hospital refusing to see migrants and sending them on to Coronation Hospital. Two of the ten doctors interviewed (20% of respondents) explained that Johannesburg Hospital is classified as a tertiary hospital, whereas Coronation and Helen Joseph Hospitals are classified as secondary hospitals. [126] This means that Johannesburg Hospital should be providing a higher level of care than Coronation and Helen Joseph Hospitals. Despite this distinction, Johannesburg Hospital continues to refer patients to Coronation and Helen Joseph Hospital. This means that the two hospitals are operating on a budget for a secondary hospital but having to provide tertiary care.

The ability of Johannesburg Hospital to turn away patients seems to be embedded in a historical perception that it is a more superior hospital.[127] This perception exists because prior to 1994, the hospital served a predominantly white population. On the contrary, Coronation Hospital has always been perceived to be a hospital which serves the poorer South African population who do not have the same resources as patients attending Johannesburg Hospital. In the same vein, the classification of Johannesburg Hospital as a tertiary facility has been used as a means to avoid treating certain categories of patients on the grounds that it provides specialist services.

One of the consequences of this is that Coronation Hospital is seeing patients from as far as Hartebeespoort Dam, Diepsloot, Alexandra, Mayfair, Fordsburg, Krugersdorp, Eastern Soweto, Ennerdale, and areas such as Bertrams and Bezuidenhout Valley. Areas such as Bertrams and Bezuidenhout Valley both fall outside the catchment area of Coronation Hospital. To some extent, this has also come to mean that the hospital can not provide the same level of care which would be possible if it was serving a smaller population.

[125] Respondents A,D,E,G,I,L,N,O,R
[126] Interview with Respondent 6, 27 January 2004; Interview with Respondent 9, 8 February 2005.
[127] Interview with Respondent 6, 27 January 2004

These resource constraints affect all patients using the hospital, whether or not they are South African. But, in the context of migrants already feeling vulnerable and not having a clear sense of the way the health system works, these barriers could easily be perceived as deliberate discriminatory behaviour.

6. RESPONSES OF MIGRANTS TO ACCESS CONSTRAINTS

The previous two chapters have sought to record and interrogate the perceived barriers Somali migrants face when accessing health services in Johannesburg. However, this study is not only concerned with recording the discrimination and hardship endured by forced migrants in Johannesburg. The study is also concerned with identifying and exploring how Somali migrants negotiate these constraints. This chapter will identify and discuss the strategies employed by migrants to meet their health needs and the extent to which such strategies are successful. The word 'strategy' is used loosely to refer to a set of practices employed by migrants to gain access to health care whether or not such practices are carefully considered, well thought through and executed step-by-step.

6.1 Strategies used by migrants to overcome barriers to access

The strategies discussed below serve many different functions. Some of the strategies are used to gain access to the formal public health system. Others are used to meet health needs outside of the formal system.

While the study was expected to generate instances of migrants breaking the law, this has not occurred on a large scale.

6.1.1 Attempts to engage with the formal system

There is evidence that migrants try to overcome barriers by engaging with different elements of the health system.

One female migrant spoke of waiting at the Mayfair Clinic with her sick child and despite being there early, being ignored. She reported being told by the clinic clerk to return the following day and in a desperate attempt to get treatment, asked the guard to write a letter for her requesting that the child be seen.[128] The guard refused to help her.

In another instance, a female Somali migrant had threatened to call the police after being turned away from being seen at the clinic.

[128] Interview with Respondent E, 10 May 2004

The migrant says she was told by the nurses that they "do not give a damn and that she should go ahead and call the police."[129] These practices indicate that some migrants endeavour to invoke the assistance of others in order to secure access. However, these attempts are largely unsuccessful. This behaviour may also indicate that migrants attach much value to formal health care and desire to continue to try to gain access to the formal health system at all costs, and only utilise alternative resources as a last resort.

6.1.2 Payment of high user fees

As noted in the previous chapter, eight of the migrants interviewed for this study (40% of respondents)[130] reported having to pay high user fees to gain access to health care or being turned away when they have sought access to a health facility in Johannesburg. While only 40% of migrants admitted to experiencing this themselves, fifteen of the migrants interviewed (75% of respondents) raised this as a barrier to health care access experienced by Somali forced migrants.[131]

The large disparity in fees charged both within and between facilities indicates an inconsistency in practice. The fact that all public hospitals are managed and funded by provincial and national government indicates that their should be a standard fee charged irrespective of the facility being used. Where this discrepancy has varied between R20 and R164, the majority of migrants indicated that they tried to pay the amount. However, the practice of Johannesburg Hospital charging forced migrants R1800.00 was more difficult to overcome. One female migrant reported knowing of a female Somali migrant who arrived at Johannesburg Hospital in labour and needed to be admitted. She was told that she needed to pay R1800.00 and was refused admission because she could not pay. The clerk went on to tell her to "stop pushing". The Somali woman gave birth to her baby at the entrance to the hospital, without having been admitted.[132]

The practice of Johannesburg Hospital charging R1800.00 to forced migrants may also partly explain the large population of foreign migrants seeking care at Coronation Hospital and Helen Joseph Hospital. One male migrant (10% of male respondents) reported instances where migrants were admitted but were not allowed to leave the hospital until they had paid the R1800.00 fee.[133] Migrants who reported being unable to

[129] ibid
[130] Respondents A,D,I,E,F,G,K,T
[131] Respondents A, B, C, D,E, G, I, J, K, L,N, O, P, R, T,
[132] Interview with Respondent B (2) 15 February 2004
[133] Interview with Respondent H, 18 October 2004

pay R1800.00 for access confirmed that they seek alternative care at Coronation Hospital and Helen Joseph Hospital. There were no reports by migrants of being asked to pay R1800.00 for access at Coronation Hospital.

The same male migrant stated that he believed if someone could not pay the community must help by making financial contributions to the fee. He went on to say that it is better to lose your job because you helped someone than to leave someone in pain. Following on from this, he said that if someone does not help a sick person because they are scared to lose their job, then they do not believe in Allah.[134] The respondent explained this perspective as being informed by religious beliefs and an individual desire to help. This is the only time during the study that respondents reported using religious or cultural beliefs to inform choices and behaviour in relation to health care.

6.1.3 Lodging a complaint

The CASE study[135] documents that only 1% of refugees that were refused access to basic health care lodged a complaint.[136] This can be attributed to not knowing what to do and where to complain, being unable to communicate in English[137] or to the belief that complaining will not result in any material improvement and will only add to the xenophobic attitudes held by many South Africans. The CASE study confirms that 24% of refugees reported doing nothing about being refused access because they did not know what to do.

The practice of lodging a formal complaint is not employed regularly by Somali migrants and only seldom secures access to the health care system. The previous chapter records that only two of the twenty (10% of respondents) Somali migrants interviewed had lodged a formal complaint about poor service they experienced when attempting to access health care at a public hospital. Both of these migrants are able to communicate comfortably in English. This may be a factor which influences the decision to complain.

The tendency for women to use health services more frequently than men may also partly explain the fact that only a small proportion of Somali migrants have lodged a

[134] ibid
[135] Belvedere, F et al (2003) National Refugee Baseline Survey: Final Report CASE & Japan International Co-operation Agency
[136] This study surveyed many migrant groups. The statistic provided does not refer specifically to Somalis.
[137] Interview with Respondent D, 3 May 2004; Interview with Respondent E, 10 May 2004.

formal complaint about poor service. This may be due to women being unable to communicate in English or the gender roles and social norms which influence the way women conduct themselves in broader society.

There are two well-known instances of refugees having pursued legal action as a result of experiencing discrimination or being denied access to health care. The first case occurred in February of 2004 and pertained to a refugee who was requested to pay very high user fees at the South Rand District Hospital.[138] This case was pursued by the Papillon Foundation, an organisation which forms part of the Methodist Church and provides a variety of services to forced migrants. The forced migrant was subsequently granted access and a memorandum was circulated to all admission clerks by the hospital ensuring that this does not occur again.

Many NGOs have taken up the same issue with Johannesburg Hospital. To date, there has been no success and forced migrants are still being subject to very high and inconsistent user fees.

The second instance of legal action was discussed in the previous chapter. It refers to a female Somali migrant lodging a case against the Operations Manager of Mayfair Clinic for being unfairly treated and publicly humiliated.[139] To date, I am unaware of the outcome of this case.

Though very few Somali migrants lodge a formal complaint when they experience discrimination while accessing health care, there is a tendency for Somali migrants to complain to each other about their experiences trying to access services. Sometimes it can even happen that migrants take on the experience of other migrants who may have been denied access as their own. While this has little to no influence or possibility for change, the strategy may function as a way of migrants affirming their identity of vulnerability and suffering. This was brought to my attention on two separate occasions during my fieldwork.[140] In both instances, my research assistant openly questioned the narrative being provided by the interviewee. Both of the narratives were true, but had been experienced by someone other than the person being described.

6.2 Alternatives to using public health care

[138] Memorandum drafted by Papillon Foundation on 11 February 2004 pertaining to Mrs Kikotso Tuandaka being asked to pay very high user fees for access.
[139] Interview with Respondent B, 12 November 2004
[140] Interview with Respondent D, 3 May 2004; Interview with Respondent L, 24 November 2004.

The previous section documented some of the strategies employed by migrants to gain access to the formal health system. Some of these strategies require migrants to be complicit in illegal practices by paying the requested bribes and high user fees so as to gain access to the formal system. Other strategies have involved migrants trying to invoke their rights by lodging a complaint about the quality of service provided to them. Neither of these practices have involved migrants fraudulently assuming alternative identities in order to gain access.

The following section will identify and discuss some of the strategies employed by Somali forced migrants to meet their health needs outside of the formal public health system.

6.2.1 Use of alternative sources of care

One of the initial hypotheses of this study was that there existed Somali doctors or nurses within the Mayfair community who were providing particular health services to Somali migrants outside of the structure of the formal health system.

The second hypothesis was that Somali migrants were using some form of traditional medicine to treat basic health problems without having to use clinic services. Both of these hypotheses were disproved in the study. At no time in the study did I hear of any Somali 'community doctor' or anyone using traditional home remedies in place of formal health services. This may suggest that such medicines are not readily available or that migrants denied such use for fear of being considered 'backward'. Any of the medication or practices that Somalis were using at home were the same as those widely practiced in many homes, irrespective of ones race, culture or religion.

Of the migrants who did not use the public health system, there was no consistent pattern as to what health services were being used. However, there were certain resources that were used more frequently.

One of the more common methods used by migrants was purchasing over-the-counter medication at a pharmacy. This medication tended to be analgesics, mild strength pain killers or cough medicine. While these medicines are no different to those used by the general public, the motive for using them differs slightly. Three of the migrants interviewed had purchased medicine from a pharmacy when they had been unable to

gain access to health services.[141] In all three incidents, the women had sought care at the Mayfair Clinic and been turned away without being seen. In one instance where a female migrant had been turned away from the clinic, the symptoms experienced had worsened after taking over-the-counter medication and the female migrant sought care at a private hospital.[142] This utilisation pattern differs somewhat to that practiced by the general public, who if they can afford it, are more likely to visit a pharmacy for over-the-counter medication before going to a hospital.

While the UJP survey did not include using a pharmacy as an option for obtaining health advice, 93.2% of Somalis surveyed still said they would seek health care at a clinic or hospital. This statistic suggests that despite the constraints reported by migrants many continue to attend hospitals and clinics. It is unclear whether the motive for this is that there is no other alternative available, or whether the constraints reported by migrants form part of a strategy to draw attention to the difficulties and hardship experienced by migrants, as a way of establishing the 'cause' of refugees as a legitimate priority.

There was some evidence of migrants accessing private health care at Garden City Clinic, a large private hospital in Mayfair. During my fieldwork, it came to my attention that some migrants were bypassing the public health system completely and accessing care at private facilities as a first source of care. In other instances, using the private health care system was a last resort. One of the reasons provided by migrants was that private health care in South Africa is very expensive.[143] It is out of reach for the majority of the South African population who rely on the public health system. It is likely that it is equally, if not more expensive for the majority of Somali migrants in Johannesburg. Though only a few Somali migrants had used private health care facilities, six migrants (30% of respondents) believed that the care provided was better and that you were given more medicine at a private facility.

While many migrants can not afford private treatment at Garden City Clinic, some migrants regularly use the services of a South African 'Indian' doctor who has a private practice in Mayfair. Migrants seemed to use this doctor if they had been unable to gain access to the hospital or clinic or if they did not have the time to wait to be seen. This doctor is well-liked and is thought to be very understanding by many of the migrants interviewed. A male migrant attributed this to the doctor always allowing migrants to

[141] Interview with Respondent D, 3 May 2004; Interview with Respondent E, 10 May 2004; Interview with Respondent I, 25 October 2004.
[142] Interview with Respondent I, 25 October 2004.
[143] Interview with Respondent A, 24 January 2004; Interview with Respondent R, 25 October 2004

explain what they thought was the problem before deciding on treatment.[144]

One of the female migrants interviewed described needing to take her child to see this doctor, but being unable to pay the fee required. Despite being unable to pay, the doctor saw and examined the child and agreed that the female migrant could pay him at a later point. She describes returning to pay him over a year later, and that this arrangement has continued, whereby he will not refuse to see a patient if they are unable to pay at the time of being seen.[145] One of the male migrants interviewed described this doctor as being a "good person." It was unclear whether the respondent thought this behaviour was motivated by his faith (Islam). [146]

As a result of treating many Somali migrants over the years, the doctor is also able to understand a few words of Somali. One male migrant reported that this assists in establishing a rapport and a feeling of familiarity that migrants do not experience when using the formal public health system.

[144] Many Somali migrants commented during my fieldwork that Somalis often believe they know what is wrong with them, and only need it confirmed by a doctor. This goes some way to explaining the experience of many migrants being frustrated because they feel they are not being given sufficient medicine.
[145] Interview with Respondent B, 12 November 2004
[146] Interview with Respondent P, 24 November 2004

7. CONCLUSIONS AND IMPLICATIONS

7.1 Conclusions

This study tried to explore a number of questions in relation to Somali forced migrants access to health care in Johannesburg. The study investigated how the implementation of health policy at facility level enables or constrains access to health care for forced migrants. In relation to this, the study looked at specific constraints identified by forced migrants and health personnel, and how forced migrants try to overcome such constraints, in order to gain access to the formal health care system.

The existence of contrasts in perceptions of constraints between doctors and migrants means we are faced with two alternatives. The first is to accept that doctors have the correct perspective on a system that is unable to provide access to the many people who require it. Accepting this position, means accepting, by implication, that the perspectives and expectations of migrants may be at least partially incorrect and unreasonable.

The other alternative is to accept that the perceptions of doctors are a further mark of xenophobia whereby doctors see these constraints and refuse to recognize them as a problem. This would by implication mean that what migrants report is a true reflection of the functioning of the health system at all levels.

Evidence exists for both interpretations. Two main conclusions can be drawn from the detailed qualitative interviews conducted with both Somali forced migrants and health personnel and a thorough analysis of their responses.

7.1.1 Agreement between migrants and between migrants and doctors on patterns of discrimination

The study confirmed that there is in fact a gap between the rights guaranteed in the Constitution and the Refugees Act and the way these rights are provided for. The Constitution and the Refugees Act are considered to be quite progressive legislation in that they clearly specify and commit to the provision of socio-economic rights, yet the extent to which the commitment contained in the Refugees Act is realized in practice is limited. While this can be partly attributed to limitations in available resources, it is also very clear that irrespective of policy commitments, the ability of Somali forced migrants

to claim their rights is limited by practices at facility level.

This conclusion is drawn from the fact that, first, there were many similarities in the patterns of constraints identified by many migrants; and second, there are many areas of agreement in the perceptions of constraints identified by migrants and health personnel.

The most notable similarities in the experience reported by migrants are in respect of being made to pay high user fees, differences in understanding of how the health system works, language barriers and being asked for bribes from various different actors in the health system.

Compellingly, the areas of agreements between the perceptions of doctors and migrants are precisely with respect to these same four constraints.

These mutually confirmatory perceptions suggest a weight of evidence behind the conclusion that migrants experience a fairly severe level of constraint when accessing health care.

7.1.2 Doctors' Perceptions

The fact that doctors confirm some of what migrants express is good evidence to suggest that the contrasting perspectives of doctors need to be taken seriously. These contrasting perspectives suggest that ones identity as a forced migrant is not the only variable which determines access to health care.

In fact, it is likely that many of the contrasting perspectives held by doctors may not simply be due to a lack of knowledge, but rather a reality of the resource constraints within a system which is already under-resourced and over-stretched. It is such constraints which limit access to health care for all the population, and the way these constraints are played out in service delivery are not an intentional attempt to exclude forced migrants.

Many of the constraints experienced by migrants when trying to access the health system are experienced by all people using the public health system. Though migrants may experience these constraints in a very particular way, they can not be solely attributed to and explained by ones identity as a forced migrant.

However, this is not to suggest that migrants are not subject to xenophobic behaviour and discrimination while accessing health care.

7.2 Implications

7.2.1 Implications for an appropriate policy response

This study has sought to make a contribution to the limited literature on health care access among self-settled communities. It has identified and confirmed commonly understood access barriers faced by migrants when attempting to gain access to health care and associated social services. This section will seek to discuss some of the implications of this study and possibilities for small scale intervention.

It needs to be established at the outset of this discussion, that this study and the recommendations included below are not directed at securing policy change and determining the future actions of large donor agencies. This study can only inform and hope to provide ideas and recommendations for actions at a micro level. Assuming that a study like this and the findings generated herewith are significant enough to shape policy is presumptuous and lays a claim to a body of knowledge and expertise which far exceeds the scale of this study.

This study has identified specific constraints which have been mutually recognized by both health personnel and forced migrants. That doctors have recognized and acknowledged such constraints opens up capacity for intervention at facility level.

In many instances, the people responsible for barriers to access at the first point of contact are external to the delivery of health care, and are not managed by health care personnel. Staff such as guards and administrators offer independent services, and are accountable to the administrative head of the hospital. This means that spending large amounts of money on education about migrant rights is not necessarily going to translate into improved access. The presence of posters and information about who is entitled to health care are located throughout Coronation Hospital. They are especially visible on the ground floor.

This indicates that money has already been spent on education, and that producing posters and providing knowledge will not automatically result in a material change in behaviour.

In the same way, it is not standard practice that forced migrants are required to present documents to verify their entitlement to primary health services when using district level clinics. Education about migrants rights and documents is thus not appropriate for clinic level staff.

The broad recognition of the enormity of the language barrier which many migrants face has prompted the standard reaction that hospitals must employ interpreters to translate for migrants. The large volume of migrants from throughout the region and the continent means that the demands for interpretation and translation will be unreasonable. This deployment of resources is neither realistic or feasible. One intervention which may have a greater prospect for change is for NGOs and organizations working with migrants to begin to provide some classes which teach a level of functional English that will enable forced migrants to communicate at a basic level and in such a way that they are able to utilize the health system more effectively while facilitating greater integration with the host community.

However, this does not mean that there is no scope for intervention or change. As health personnel are not responsible for the management and functioning of the hospital, resources may be better directed towards lobbying the administration to put in place tighter codes of conduct to make auxiliary staff more accountable for their actions. Literature which looks at health worker performance attributes poor performance at work to poor working conditions, lack of communication and poor management practices.[147] In South Africa, this is a major issue in the public sector. Though this study did not interview nurses working at the hospital, it became increasingly apparent that doctors were aware of these issues and acknowledged the problems that result from such behaviour. The shortage of nurses caused by attrition overseas and to the public sector, mean that many public sector posts are vacant and nurses are facing increasing workloads with no consequent increase in resources.[148]

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[147] Gilson et al (2004) Exploring the Influence of Workplace Trust over Health Worker Performance. Preliminary National Overview Report: South Africa. *Prepared for Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine*

[148] Padarath, A et al. (2003) Health Personnel in Southern Africa: Confronting maldistribution and brain drain EQUINET & Health Systems Trust

Such difficult working conditions, a lack of management support and resource shortages all contribute to patients being treated poorly by nurses. It is important to note that this issue does not only affect migrants, but is broadly experienced by all users of the public health system.

Experience has shown that one of the most effective ways to secure the fulfillment of the rights and entitlements guaranteed to migrants is to invoke the legal system. One of the best practices of this has been to make the heads of institutions and organizations accountable for the actions of lower-level staff. This will contribute to securing the commitment of actors within the health system to respond to these issues.

It is imperative that stakeholders within the health care system recognize that for this issue to be best addressed there needs to be greater co-operation and collaboration between the administration and the point of health care provision. It is not sufficient to see the responsibility for securing access and a quality of treatment which matches that available to South Africans as someone else's responsibility.

All of the above implications refer to the actions of staff and external organizations. It needs to be acknowledged that this study is not equipped to conclude with clear recommendations to policy makers or international agencies as to how they should conduct programmes aimed at alleviating these constraints. It also can not be assumed that the only way to realize change in the ability of migrants to access care is to seek to mobilize resources and people within the system. This approach further entrenches the perception that migrants are passive recipients of poor treatment and xenophobic behaviour, and have no capacity to act on their environment. Securing changes in access can not rely on the belief that changing internal functioning of the system will result in the elimination of all access constraints which forced migrants face.

If change is to happen, migrants need to begin to take on a more active role as participants in a system with the power to act and shape this system in some way. As this study does not seek to generate broad implications for policy change and the implementation of programmes by aid agencies, it is difficult to suggest how these actions should take place.

7.2.2 Implications for the field of refugee studies

Refugee Studies has a tendency to dismiss out of hand the position that holds that an

under-capacitated government system, unable to provide for the needs of a majority of the population, is not automatically acting to deny migrant rights. However, it is prudent not to dismiss the perceptions of some of the health workers interviewed in this study that it is system inadequacy, not deliberate acts of discrimination that causes migrants to feel that their rights have not been respected. The implications of this need would need to be considered more carefully in further study, that weighs the human rights seemingly automatically guaranteed forced migrants by international convention, against the thrust of an emerging constitutional jurisprudence on socio-economic rights in South Africa, in particular cases that grapple with the question of whether a right guaranteed under various constitutional clauses that speak of 'progressive realization', but which have not yet been realized because of government incapacity, can be counted as rights infringed or denied.

In regarding literature in the field of refugee studies as normatively over-determined, some may conclude that many of the constraints reported by Somali forced migrants form part of a forced migrant 'strategy' directed at drawing attention to the vulnerability and discrimination. In this view, forced migrants' 'victimhood' is an identity strategy that aims to secure power. This issue needs further attention. The constraints raised by migrants do need to be recognized and taken seriously. However, in a context where populations as a whole face many constraints, how forced migrants perceive their special claim to rights, and under what circumstances they and others would regard this special claim as valid or not, needs further investigation. The differences in perception between health personnel and forced migrants provided a useful entry point into this kind of study, and this research strategy could be pursued further.

This study has begun to make a contribution to the limited literature on health care access among self-settled refugee communities and the existing body of literature which looks specifically at the implementation of socio-economic rights. However, it is clear that much fruitful further research in these areas is possible and necessary.

8. APPENDIX: DETAILS OF MIGRANTS AND DOCTORS INTERVIEWED

8.1 Biographical details of forced migrants interviewed

The following gives a brief description of each of the migrants interviewed.

Respondent A is a female Somali forced migrant who arrived in South Africa in 1997. She was awarded her refugee status in 1999 which was valid until 2001, after which it needed to be renewed. She is still waiting for the renewal to be processed. She has had one child since arriving in SA. The child was born at Coronation Hospital. She has been to Johannesburg Hospital, Coronation Hospital, Mayfair Clinic and Helen Joseph Hospital. She is unemployed and is unable to speak English.

She was interviewed on 22 January 2004.

Respondent B is a female Somali forced migrant. She is 33 years old. She arrived in South Africa in 1995 and spent the first four years in Cape Town. She came to Johannesburg in 1999. She has been awarded refugee status, which required renewal in 2004. Since arriving in South Africa, she has had 3 children. Her first child was born in Cape Town and the other two were born at Coronation Hospital. She has been to Johannesburg Hospital, Coronation Hospital, Helen Joseph Hospital and Mayfair Clinic on many occasions. Her interviews reflect both her own direct experiences and those that she has witnessed while accompanying Somali migrants to health facilities. She speaks good English and regularly accompanies Somalis who require a translator to the hospital or clinic. She was employed as a nurse in Mogadishu prior to fleeing in South Africa. Since arriving in Johannesburg she has been employed as a home based care worker by Jesuit Refugee Services. She obtained resettlement to Australia in March of this year.

She has been interviewed 5 times since the start of the fieldwork on 24 January 2004, 15 February 2004, 4 May 2004, 11 August 2004 and 12 November 2004 respectively.

Respondent C is a female Somali forced migrant. She is 31 years old. She came to South Africa in 2000. She is still awaiting the outcome of her application for asylum. She has three children. She has married a male Somali forced migrant since arriving in 2000. They have two children together. She has been to Coronation Hospital, Helen Joseph Hospital

and Mayfair Clinic. She supports herself by selling small goods on the roadside. On two occasions her goods have been confiscated by Metro Police. She is not working currently. She can speak English.

She was interviewed on 22 February 2004.

Respondent D is a female Somali forced migrant who arrived in South Africa in 2002. She is still awaiting the outcome of her application for refugee status. She has been to Helen Joseph Hospital and the Mayfair Clinic. She has one eighteen year old son but has not had a baby since arriving in South Africa. She is unemployed and is unable to speak English.

She was interviewed on 3 May 2004

Respondent E is a female Somali forced migrant. She is 19 years old and arrived in South Africa at the beginning of 2004. She spent her first three months in Cape Town where she lodged her asylum application. She is still awaiting the outcome of her application for refugee status. She left Somalia with her baby who was three months old when they left. It took her three months to reach South Africa from Somalia. She has used Coronation Hospital and Mayfair Clinic. She came to South Africa without the father of her baby. She is unemployed and is unable to speak English.

She was interviewed on 10 May 2004.

Respondent F is a female Somali forced migrant. She is 64 years old. She arrived in South Africa in 1996 and has been awarded refugee status three times. Her permit requires that she renew her status each year. She travelled to South Africa on her own. Her adult children were awarded asylum in Holland and are still living there. She has used Johannesburg Hospital and Helen Joseph Hospital. She currently attends the Orthopaedic Unit at Helen Joseph Hospital because of a bullet wound in her lower back she sustained before fleeing. She is unemployed and can speak very basic English.

She was interviewed on 9 June 2004.

Respondent G is a female Somali forced migrant. She is 21 years old. She arrived in South Africa in 2003 and is still awaiting the outcome of her asylum application. She has had one child at Coronation Hospital since arriving in South Africa. She has used

Coronation Hospital and Mayfair Clinic. She is unemployed and is unable to speak English.

She was interviewed on 9 June 2004.

Respondent H is a male Somali forced migrant. He is approximately 28 years old. He came to South Africa in 1997 and has been awarded refugee status. He has been to the casualty units in Helen Joseph Hospital and Johannesburg Hospital. He speaks English and runs a small business in the Inner City.

He was interviewed on 18 October 2004.

Respondent I is a female Somali forced migrant. She is 21 years old and arrived in South Africa in 2002. She is currently awaiting the outcome of her application for refugee status. Since arriving in South Africa she became pregnant and later had a miscarriage. She received care at Coronation Hospital after the miscarriage. She is unemployed and can not speak English.

She was interviewed on 25 October 2004.

Respondent J is a male Somali forced migrant. He is approximately 64 years old. He arrived in South Africa in 1999 and is a recognised refugee. He came to South Africa physically disabled after being shot in his lower back in 1991. He is without any family and relies on other people to assist him to get dressed and to move about. He has received a wheelchair from the Hillbrow Clinic. He has used the Mayfair Clinic and Helen Joseph Hospital. He is unemployed and can not communicate in English.

He was interviewed on 25 October 2004.

Respondent K is a male Somali forced migrant. He is approximately 27 years old. He arrived in South Africa in 1996. He has been awarded refugee status. He has attended the Casualty Unit at Helen Joseph and has used a municipal clinic in Cape Town. He is unemployed. He speaks English well.

He was interviewed on 17 November 2004.

Respondent L is a male Somali forced migrant. He is 26 years old. He arrived in South

Africa in 1994 and is a recognised refugee. He has lived in Durban and Johannesburg since arriving in South Africa. He has studied at an undergraduate and postgraduate level since arriving in South Africa. He has used Helen Joseph Hospital, Johannesburg Hospital, Mayfair Clinic and King Edward and Addington Hospitals in Durban. He regularly accompanies the elderly to Coronation Hospital to act as a translator. He speaks fluent English and is currently pursuing full-time post graduate studies.

He was interviewed on 24 November 2004.

Respondent M is a male Somali forced migrant. He is 28 years old and arrived in South Africa in 1997. He is a recognised refugee. He lived in Mpumalanga before moving to Johannesburg. He has used Johannesburg Hospital and a clinic in Mpumalanga. He speaks basic English.

He was interviewed on 8 July 2004.

Respondent N is a female Somali forced migrant. She is approximately 29 years old. She arrived in South Africa in 2003 and at the time of interviewing her, she was awaiting the outcome of her application for asylum. During the period of this study, she gave up her application for refugee status and returned to Kenya. She was living in Mpumalanga prior to moving to Johannesburg. While living in Mpumalanga she fell pregnant and subsequently miscarried in the early stages of her pregnancy. She blames the poor medical treatment she received in Mpumalanga for her miscarriage. In 2004, she gave birth in Coronation Hospital. She has used both Coronation Hospital and the Mayfair Clinic. She is unemployed and can not speak English.

She was interviewed on 16 August 2004.

Respondent O is a female Somali forced migrant. She is 17 years old. She came to South Africa with her family who have subsequently moved to England. At the time of the interview, she was awaiting the outcome of her application for asylum. She has used Coronation Hospital and the Mayfair Clinic. She was married to a male Somali forced migrant in South Africa at the age of 15. She has a daughter from her marriage that is 2 and half years old and was born at Coronation Hospital. Her husband has left her and at the time of interviewing her, she had been taken in and was living with Respondent B. She is unemployed and can speak very basic English. In February of this year she gave up her application for asylum and returned to Somalia with her daughter because she had no

one to look after her when Respondent B resettled to Australia in March.

Respondent P is a male Somali forced migrant. He is 22 years old. He came to South Africa in 1997. He is a recognised refugee. He has lived in Johannesburg since arriving in South Africa. He has been to Coronation Hospital, Helen Joseph Hospital and Johannesburg Hospital. He regularly acts as a translator for Somalis who can not speak English. He has also accompanied the elderly who require physical assistance to hospitals In 2001, two of his younger brothers arrived in South Africa They are staying together. Both of his brothers are awaiting the outcome of their application for asylum. He speaks fluent English and works at a bar at night to earn an income to support himself and his siblings.

He was interviewed on 24 November 2004.

Respondent Q is a male Somali forced migrant. He is 20 years old. He came to South Africa in 2001. He is currently awaiting the outcome of his application for refugee status. He has been to the Casualty Unit at Helen Joseph Hospital. He speaks basic English and is unemployed.

He was interviewed on 17 November 2004.

Respondent R is a male Somali forced migrant. He is 24 years old. He came to South Africa in 2002. He is currently awaiting the outcome of his application for refugee status. He has been to the Casualty Unit at Helen Joseph Hospital and Johannesburg Hospital. He speaks very little English and is unemployed.

He was interviewed on 25 October 2004.

Respondent S is a male Somali forced migrant. He is 29 years old. He came to South Africa in 2001. He is a recognised refugee. He speaks English and runs a small business.

He was interviewed on 18 January 2005.

Respondent T is a male Somali forced migrant. He is 34 years old. He came to South Africa in 1999. He stayed in Cape Town initially and came to Johannesburg in 2002. He lodged his application for asylum in Cape Town. He speaks basic English and is working, but his occupation is not known. He was interviewed on 18 January 2005.

8.2 Short descriptors of medical staff interviewed

Respondent 1 is a female doctor working in the Unit of Obstetrics and Gynaecology. She is not South African. She was interviewed on 20 December 2003

Respondent 2 is a female doctor who was working in the Paediatric Unit while completing her internship. She was interviewed on 31 December 2003

Respondent 3 is a female doctor who was working in the Paediatric Unit while completing her internship. She was interviewed on 18 December 2003

Respondent 4 is a female doctor who was working in the Paediatric Unit while completing her internship. She was also interviewed on 18 December 2003

Respondent 5 is a male doctor who was working in the Paediatric Unit at Coronation Hospital at the time of being interviewed. He is from Congo-Brazzaville and has since left the hospital. He was interviewed on 24 December 2003.

Respondent 6 is a female doctor who was working in the Paediatric Unit at the time of being interviewed as a Consultant. She has since left the hospital. She was interviewed on 27 January 2004.

Respondent 7 is a male doctor who works in the Paediatric HIV unit at Coronation Hospital. He was interviewed during December 2003.

Respondent 8 is a male doctor. He is the Professor of Paediatrics at Coronation Hospital. He was interviewed on 3 February 2005.

Respondent 9 is a male doctor. He is the Head of Obstetrics and Gynaecology at Coronation Hospital. He was interviewed on 8 February 2005.

Respondent 10 is a female nurse who was previously working in the Mayfair Clinic before the change in the demarcation of areas by local government in late December 2000.

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