

https://dspace.org/

Influences of xenophobia on accessing health care for refugees and asylum seekers in Johannesburg

Nkosi, Nomcebo Gugu

2014-07-03
http://hdl.handle.net10539/14863

Downloaded from a DSpace repository. https://dspace.org/

INFLUENCES OF XENOPHOBIA ON ACCESSING HEALTH CARE FOR REFUGEES AND ASYLUM SEEKERS IN JOHANNESBURG

Nomcebo Gugu Nkosi

A research report submitted to the Faculty of Arts in partial fulfilment of the requirement for Masters Degree in Arts, April 2004.

INFLUENCES OF XENOPHOBIA ON ACCESSING HEALTH CARE FOR REFUGEES AND ASYLUM SEEKERS IN JOHANNESBURG

Nomcebo Gugu Nkosi

A research report submitted to the Faculty of Arts in partial fulfilment of the requirement for Masters Degree in Arts, April 2004.

The copyright of the above-mentioned described thesis rests with the author or the University to which it was submitted. No portion of the text derived from it may be published without the prior written consent of the author or University (as may be appropriate). *Short quotations may be included in the text of a thesis* or dissertation for purposes of illustration, comment or criticism, provided full acknowledgement is made of the source, author and University.

ABSTRACT

The purpose of this study is to identify the effects of xenophobia on the ability of refugees to access both primary health care and hospital services in Johannesburg, South Africa, and to investigate possible barriers that may emanate from xenophobic attitudes and perceptions and make access to health care difficult or impossible. This is done through an analysis of refugees' experiences in relation to accessing health care. It is also based on the views provided by health care providers and a service provider. The study uses a control group to ascertain whether xenophobia is a barrier in accessing health care for refugees and asylum seekers. The analysis will show that there are other influential factors such as language, socio-economic status, legal status and social exclusion that can be linked to xenophobia and thus accessing health care for refugees and asylum seekers becomes difficult.

The data in this study was collected through both qualitative and quantitative methods. The methodology involved interviews with 30 refugees and asylum seekers who currently live in Yeoville, Bertrams, Berea and Mayfair. 6 health care providers from Hillbrow clinic and the Johannesburg General Hospital as the referral centre for people resident in many parts of Johannesburg, the Director and two officers of Jesuit Refugee Service, a service provider and 15 South Africans as a control group. To supplement the findings of the study, quantitative data on key issues relating to health care from the survey conducted by the Joburg Project of the School of Forced Migration Studies (FMSP) at the University of the Witwatersrand was also used.

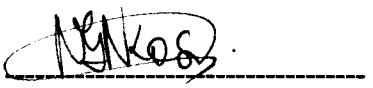
The findings of the study revealed that xenophobic tendencies and attitudes of health personnel are very subtle though are linked to barriers such as language, socio-economic and legal status of asylum seekers. The findings also unfolded that asylum seekers will continue to suffer due to the lengthy asylum status determination procedures, as this keeps their life on "hold" which may contribute to affect their health status, and the high hospital fee that the asylum seekers are expected to pay. Finally, the evidence gathered in this study show that almost all respondents identified lack of information on how the health system works leading to inadequate access as a major problem.

DEDICATION

This work is dedicated to my lovely children Nonkululeko, Simphiwe and Gcinile for their encouragement in a special way.

DECLARATION

I hereby declare that this project is my original work, achieved through research studies and critical observation and that it has never been submitted to the university for academic credit. The information and other sources have been duly acknowledged as required.



05/04/2004

Nomcebo Gugu Nkosi

ACKNOWLEDGEMENTS

The presence and assistance of the following people is greatly accredited:

- Professor Mda for his outstanding support and encouragement without which I could not have completed this research.
- My supervisor Loren Landaul for his guidance throughout the project.
- Bea Abrahams Africa Manager at the CSVR for her contribution to this project.
- The different Refugee Communities in Johannesburg for their willingness to partake in this project.
- I thank my sister Patricia and her husband Clement for every support they gave me throughout this discourse.
- I would like to thank my friends and colleagues for their helpful suggestions, comments and moral support. These include Ingrid Palmary, Zozo Masimula, Gugu Mkhonta, Elizabeth Muiruri, Tesfalem Tekleab Araia, Takwana Makaya, Bongani Mthobi, Jeanne Izabiliza, Millan Atam, Alina Khasipe, Lineo Mohlabi and Philippa Lane for giving me courage when I needed it the most.
- Special thanks to my loving parents especially my mother, Josephine for her unstinting support and encouragement throughout my academic journey.

TABLE OF CONTENTS

TITLE PAGE i

ABSTRACT.....ii

DEDICATION.....iv

DECLARATION.....v

ACKNOWLEDGEMENTS.....vi

ABBREVIATIONS AND ACRONYMS.....x

CHAPTER ONE - INTRODUCTION.....1

1.1 Background of the study.....2

1.2 Rationale of the study.....8

1.3 Aim and objective of the study.....9

1.4 Research design and methodology.....10

CHAPTER OUTLINE.....11

CHAPTER TWO - LITERATURE REVIEW.....13

2.1 General background of refugee in Africa.....13

2.2 Significance to accessing health care.....15

2.3 State's obligation with regard to health rights in South Africa.....18

2.3.1 Provisions of the Constitution of South Africa.....19

2.3.2 The Refugees Act of 1998.....21

2.4 Possible hindrances to health service access.....22

2.4.1 Language.....22

2.4.2 Socio-economic status.....26

2.4.3 Xenophobia.....29

2.4.4 Social exclusion.....32

CHAPTER THREE - RESEARCH DESIGN AND METHODOLOGY.....36

Introduction.....36

3.1 Qualitative Research method.....38

3.2 Quantitative Research method.....40

3.3 Research Areas and Sampling.....41

3.4 Data Collection Method.....43

3.5 Limitations of the study.....44

3.6 Ethical Considerations.....45

CHAPTER FOUR - PRESENTATION AND DISCUSSION OF RESEARCH FINDINGS.....47

Introduction.....47

4.1.1 Language Barrier to Access Health Care.....48

4.1.2 Socio-economic Status as a Barrier.....54

4.1.3 Documentation problem as a Barrier.....60

4.1.4 Attitudes of Health Providers.....61

CHAPTER FIVE - CONCLUSION AND RECOMMENDATIONS.....68

6. REFERENCES.....72

7. APPENDICES.....81

APPENDIX A: INTERVIEW GUIDE FOR REFUGEES / ASYLUM SEEKERS IN JOHANNESBURG

APPENDIX B: INTERVIEW GUIDE FOR THE CONTROL GROUP

APPENDIX C: INTERVIEW GUIDE FOR THE HEALTH PERSONNEL

APPENDIX D: INTERVIEW GUIDE FOR THE HOSPITAL ADMINISTRATOR (KEY INFORMANT)

APPENDIX E: INTERVIEW GUIDE FOR THE SERVICE PROVIDER (JRS)

APPENDIX F: INTERVIEW GUIDE FOR REFUGEES / ASYLUM SEEKERS IN JOHANNESBURG (TRANSLATED INTO SOMALI)

APPENDIX G: INTERVIEW GUIDE FOR REFUGEES / ASYLUM SEEKERS IN JOHANNESBURG (TRANSLATED INTO FRENCH)

APPENDIX H: INTERVIEW GUIDE FOR REFUGEES AND ASYLUM SEEKERS IN JOHANNESBURG (TRANSLATED INTO PORTUGUESE)

APPENDIX I: PERMISSION LETTER GRANTED BY JOHANNESBURG HOSPITAL

APPENDIX J: MAP OF JOHANNESBURG -INDICATING STUDY SITES

BIBLIOGRAPHY

ABBREVIATIONS AND ACRONYMS

AU	African Unity
CASE	Community Agency for Social Enquiry
CSVR	Centre for the Study of Violence and Reconciliation
DHA	Department of Home Affairs
ESCR	Economic, Social and Cultural Rights
FMSP	Forced Migration Studies Programme (University of the Witwatersrand)
HFA	Health for All
HSRC	Human Science Research Council
ICESCR	International Convention on Economic, Social and Cultural Rights
IDP	Internally Displaced Persons

JRS	Jesuit Refugee Service
SAMP	Southern Africa Migration Project
SAHRC	South African Human Rights Commission
SES	Socio-Economic Status
NCCSDO	National Coordinating Centre for NHS Service Delivery and Organisation
OAU	Organisation of African Unity
OPD	Out Patient Department
UN	United Nations
UNHCR	United Nation High Commissioner for Refugees
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

This study focuses on self-settled refugees in Johannesburg, South Africa. It identifies the effects of xenophobia on refugees[1] and asylum seekers[2], ability to access health care from Johannesburg's public hospital and clinics. The study asks if factors such as language, socio-economic status, social exclusion or ignorance about their legal status in the country or xenophobia may hinder refugees and asylum seekers to access health care. By isolating the effects of xenophobia in relation to access to health care, the study will be able to demonstrate if xenophobia is the possible barrier for refugees and asylum seekers to access health care.

In a study conducted by the Community Agency For Social Enquiry (CASE) in 2001 for the United Nation High Commission for Refugees (UNHCR) there was consensus among health providers that there was lack of coherent government policy regarding health service provision for refugees and asylum seekers. In their study, there is no information based on the experiences of refugees and asylum seekers in accessing health care. In

[1]According to the 1951 United Nations Convention and the 1967 Protocol a refugee is defined as a person owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or opinion, is outside the country of hi (sic) nationality and is unable or, owing to such fear, is unable to avail himself (sic) of the protection of that country.

[2] This refers to any person who seeks in another country because her (sic) life may be threatened by certain circumstances beyond control. An asylum claim is submitted and awaits the DHA decision.

order to bridge this gap, this study is based on the different views about accessing health care from public hospitals and clinics in Johannesburg. To get a clear picture of this,

refugees and asylum seekers will narrate their different experiences in accessing health care. It is also based on the views provided by the health care workers (Johannesburg) in order to ascertain their perceptions and attitudes towards refugees and asylum seekers. The service provider Jesuit Refugee Service (JRS) also relayed views about the problems refugees and asylum seekers face when accessing health care. The study will use a control group to ascertain if South Africans also face the same barriers as refugees and asylum seekers in accessing health care. In general, the study will investigate issues around access to health care. This will show if there could be other factors such as language, socio-economic status, legal status or social exclusion that may be linked to xenophobia that creates a barrier for refugees and asylum seekers to have access to health care in Johannesburg or whether these factors act to limit access to health care independently of xenophobia.

1.1 Background of the Study

Large population movements have taken place in every century, the causes of such movements then were much the same as they are today: famine, wars, intolerance and persecution. In the current context, the effects of colonialism have created national frontiers that are now more sharply defined and more closely guarded so people can longer move with ease. The modern refugee situation is the price that is paid for

nationalism, for the development of states consequently leading to restriction of movements (Bonnerjea, 2002). Carballo & Nerukar (2001) argue that this is happening at

a time when many countries are ill- prepared to deal with a changing demography and when policies and attitudes to population movements and immigration are hardening.

In the African context, people are moving in large numbers faster and further than in other regions in the world and this has made some observers to aptly describe Africa as a "continent perpetually on the move". It is this situation that has caused approximately twenty-five million Africans to live in exile in search of better opportunities or in need of a safe haven (Hamilton, 1994). This scenario has led anthropologists such as Colson to label the twentieth century as the "century of refugee".[3] It is for this reason, therefore, that the health implications of this emerging dynamic, so replete with political contradictions, are enormous.

For South Africa, hosting refugees is a relatively new phenomenon, as during the apartheid era she was a refugee producing country. However, with instability in the continent, there has been a dramatic increase in the inflow of refugees to South Africa, and consequently has become a refugee receiving country (Majodina, 2001). South Africa is now a signatory to both the international and regional conventions on refugees, and thus, has a legal obligation to host refugees. For instance, as of January 2001, South Africa has received 60 000 applications for refugee status and the UNHCR estimates that this number will rise. Of this figure, 19 000 have been granted refugee status (Geddo,

2003). When looking at the comparison with the other countries in Africa, UNHCR statistics show that South Africa is one of the lowest recipients of refugees in Africa. In South Africa, there are not refugee camps and almost all forced migrants settle in urban areas with hope for a "better" life. In this case, Johannesburg the "city of gold" is one of the urban areas in South Africa that attracts forced migrants.

There is no doubt that the dismantling of the apartheid regime has been accompanied by a new wave of immigration-asylum seekers mainly from African countries. Margardie (2000) tells us that with the escalating numbers of refugees and asylum seekers in South Africa, the government does not seem to have strategies in place to accommodate these flows and has been using a skewed "touch and go" approach to refugees issues. Thus, the treatment of refugees and asylum seekers in South Africa does not fully comply with international refugee law and the OAU Convention. According to an investigation conducted by the Human Rights Watch, there is no legislation implementing the South African government's obligations under these agreements and all refugee-handling procedures are governed by internal regulations of the Department of Home Affairs, leaving ample room for confusion and abuse of process[4]. However, with the most progressive Constitution in place, this is a challenge for all sectors in the health care service especially for the vulnerable refugees and asylum seekers.

As mentioned refugee situations are not new, therefore, for any society that suddenly faces abrupt changes to life due to forced migration, causing internally displaced persons

[3] Journal of Refugee Studies Vol.16, No.1 2003 "Forced Migration and Anthropological Response" Elizabeth Colson, Department of Anthropology, University of California at Berkeley.

(IDP's) or those who have crossed international borders (refugees), health issues are of great concern. Health research has shown that refugee health epidemiology is very complex and wide ranging, especially given the diversity of background socio-economic status, geography and ethnicity within refugee communities (Kemp, 2003). For example, studies have shown that situations such as refugee camps, where people are living in close proximity and under difficult physical conditions, refugee health is of significance (Mears & Chowdhury, 1994; Htoon & Mickenautsch, 2000; Busza & Lush 1999). On the other hand, urban self- settled refugees face challenges in trying to access health care and this puts their health status in jeopardy.

Connolly (2002) highlights that since the overthrow of apartheid in 1994, the health care system in South Africa has been under an ongoing revolution to erase inequalities in service and access, and to fund a higher level of health care. Connolly argues that the main approach to achieving this has been to decentralise the health care system into districts and to ensure that a standard health care package is available to all. This suggests government commitment to the provision of health care for all. The Minister of Health, Manto Tshabalala-Msimango asserts, "In public health sector, we have taken seriously our obligation to ensure health care is available to all." (This Day, December 2003, p.11).

In achieving the goal of health care for all, there seem to be a number of barriers that have made accessing health care difficult or impossible for refugees and asylum seekers.

[4] "PROHIBITED PERSON". Abuse of Undocumented Migrants, Asylum- Seekers, and Refugees in South Africa, Human Rights Watch, March 1998.

In many instances, refugees and asylum seekers are discriminated against due to certain stereotypes, language barriers, and lack of knowledge or socio-economic status. In other words, refugees and asylum seekers face certain barriers, which discriminate against them, and consequently make access to health care difficult. It is for this reason that Harris (2002)[5] opines that the shift in political power in South Africa has brought about a range of new discriminatory practices and victims and one such victim is the "foreigner"[6]

Xenophobia is noted as a problem for refugees and asylum seekers in South Africa. Analysts have shown (see Morris, 1998; Tshiterete, 1999; Harris, 2002; Palmary, 2002; Shindonda, 2003; Nhlapo, 2002; Vale, 2002) that xenophobia and prejudice have been considered as the main barriers challenging refugees and asylum seekers in South Africa. They all concur that xenophobic attitudes towards refugees are explained in relation to limited resources in employment, housing, education and health care coupled with high expectations. As refugees and asylum seekers have been marginalized, they are more easily victimized and unable to access health care. Palmary (2002)[7] further argues that xenophobic attitudes among South Africans lead to unequal service delivery. According to Palmary, xenophobia, discrimination and inequality in delivery of services negatively impacts on the quality of life of refugees and asylum seekers.

To trace back the origins of these attitudes, many analysts concur that (see Reitzes, 1998; Croucher, 1998; Crush 2001) that the apartheid-era solidarities between black people

[5] Xenophobia: A new Pathology for a new South Africa? Research conducted for the Centre for the Study of Violence and Reconciliation (CSVR) by Brownyn Harris, 2002.
[6] In this study the word "foreigner" has been used to refer to migrants because it is frequently subsumed under that broader category. Otherwise it refers to refugees and asylum seekers.

regardless of national origin were crumbling even as the new, post- apartheid South African nation-building project redefined the boundaries of "us" and "them." It is these boundaries that have created stereotypes leading to discrimination and exclusion. For example, between 1994 and 1995 a study conducted by the Human Science Research Council (HSRC) to measure public attitudes on a national scale showed that there was a considerable growth of xenophobia towards immigrants, as South Africans felt that their jobs would be taken and that they would have to compete for the limited resources that the country has. Coker (2001) indicates through existing research and stories from refugees and health professionals that refugee and asylum seekers have significant health needs. The marginalised status of refugees and asylum seekers inhibits their access to health care.

The arrival of large numbers of refugees and asylum seekers in South Africa and the corresponding rise in xenophobia has been the subject of increasing research activity and attention. Geddo (2003) argues that although signs of intolerance have been reported in Botswana, Namibia and Swaziland, xenophobia is said to have reached alarming levels in South Africa, where physical attacks and abuse of foreigners by law and order authorities and ordinary citizens alike have increased significantly in the past years.[8] A Human Rights Watch report in 1998 found that "South Africa's public culture has become increasingly xenophobic. Politicians often make unsubstantiated and inflammatory statements that a "deluge" of migrants is responsible for the current ills such as the

[7] Refugees, Safety and Xenophobia in South African Cities: The role of local government. Research Report written for the Centre for the Study of Violence and Reconciliation (CSVR) Ingrid Palmary, 2002.
[8] Report on Perspectives on Refugee Protection in South Africa, "Durable Solutions to the Refugee Problem: UNHCR'S Regional Strategy for Southern Africa Chapter 4" Geddo, 2003.

current crime wave, rising unemployment and even the spread of diseases". As this perception grows, the lives of many refugees and asylum seekers become threatened. This is one issue that refugees and asylum seekers must struggle to live within a "xenophobic wave"[9]. It is this situation that has made some researchers concur that the manifestation of xenophobia is a violation of human rights[10].

Margardie (2002), argues that a great deal of information used to measure xenophobia in South Africa has been anecdotal. Margardie highlights further that this makes it difficult to quantify. Current research shows xenophobia as an extremely complex phenomenon that not only manifests itself in different forms, but also has been difficult to measure empirically.

The findings of the study show that accessing health care for asylum seekers is made difficult by certain hurdles such as language, socio-economic and legal status. Henceforth, the study revealed that there are traces of xenophobia that can be linked to the mentioned barriers in accessing health care and thus lead to social exclusion. Nevertheless, the findings further unfolded that South Africans also face certain barriers in accessing health care.

---

[9] Roll Back Xenophobia Campaign-National Plan Action, 1999.
[10] See Jonathan Crush, Southern African Migration Project / South African Human Rights Commission (SAMP), 2001.

1.2 Rationale of the study

This study will identify the effects of xenophobia on the ability of refugees and asylum seekers to access health care Johannesburg. An analysis of refugees' experiences in relation to accessing health care will show if xenophobic attitudes create barriers or if there are other factors that make access to health care difficult or impossible. This study will make a contribution to the field of urban refugee studies, in the context of a global crisis in access to health care for refugees.

Policy makers will hopefully find this study a useful guide in policy formation and intervention. The study will revisit the existing policies such as the Bill of Rights in the Constitution of South Africa which confers certain rights to "everyone" and the Refugee Act 1998 in relation to access health care. Policy makers should state in clearer terms the rights of refugees and asylum seekers in relation to access to health care, as currently there is lack of clarity. The study aims to provide information about urban refugees in South Africa and it is possible that the findings from their experiences may be able to be generalised to urban refugees in Sub-Saharan Africa. Finally, it will also be valuable in assisting vulnerable South Africans who may face similar obstacles in accessing health care.

1.3 Aim and objective of the study

The aim of this study is to investigate issues relating to access to health care and to evaluate the role of xenophobia in limiting refugees' access to health care in Johannesburg.

1.4 Research design and methodology

This study will examine the experiences of refugees' ad asylum seekers in accessing health care and how the xenophobic attitudes of health care workers may hinder or make access to health difficult or impossible. This will be accomplished by the following:

- Evaluating the narrative descriptions of refugees and asylum seekers in their different experiences accessing health care.
- Evaluating relative effects of different challenges such as language, socio-economic status, legal status, ignorance or social exclusion in accessing health care.
- Isolating the effects of xenophobia in access to health care.

To measure the effects of xenophobia on refugees and asylum seekers in accessing health care, the study will use a group of South Africans (with similar socio-economic backgrounds to the refugees) as a control group. This will be done through an analysis of their experiences in accessing health care in order to see if they face the same barriers to access or in what ways barriers to access are different.

In this study, both qualitative and quantitative methods of data gathering were used. Qualitative data was collected in Johannesburg through the use of an open-ended guideline series of interviews with refugees and asylum seekers, the control group, health care workers at local clinics / health centres and officials at the Johannesburg General Hospital, as well officers and the Director of JRS, the service provider. In conducting the interviews, a tape recorder was used to capture the responses, as some of the participants were non-English speakers.

Secondary data used for this research was published material and documents related to refugees and asylum seekers access to health care. To supplement the findings of the study, the survey data relating to health care issues from the Joburg Project of the School of Forced Migration Studies (FMSP) at the University of the Witwatersrand was also used.

Chapter Outline

Chapter 2 explores the literature dealing with refugees in Africa. It covers the literature on possible hindrances for refugees and asylum seekers in their access health care. It explains the contributions made by various authors and researchers on the subject of xenophobia. Literature on refugee health generally also introduces new themes and concepts in relation to the influences of xenophobia in accessing health care for refugees and asylum seekers. The reviews in this chapter discuss the possible barriers such as

language, socio-economic status and ignorance about refugees' legal status that may lead to social exclusion.

Chapter 3 examines the research design and methodology employed in the study.

Chapter 4 presents the findings and data analysis of the study. In this chapter the core findings of the study are based on the following barriers; language, socio-economic status, ignorance about the refugee status and social exclusion and shows if xenophobia is the predominant factor in accessing health care. It explores the stories of refugees and asylum seekers as they relate their experiences in accessing health care. It also examines at the experiences of the South Africans in accessing health care and evaluates if they face the same barriers as refugee communities. It finally relates the findings from the health providers and the key informants such as the Hospital Superintendent or Clinical Executive from Johannesburg General Hospital and the Director of the service provider, Jesuit Refugee Service.

Chapter 5 concludes the whole report, and includes recommendations that may help intervention and inform policy.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents literature about the possible hindrances to access of social services for refugees and asylum seekers. Research on xenophobia focuses exclusively on hatred towards foreigners. This study will show how this hatred or xenophobia can have an influence through creating barriers for refugees and asylum seekers in accessing health care. The literature looks at the situation of refugees and asylum seekers in South Africa and the possible factors that could influence access to health care. The factors discussed are language, socio-economic status, stereotyping and the perceptions that result in social exclusion of refugees and asylum seekers in South Africa.

2.1 General Background: Refugees in Africa

Africa has faced major refugee challenges during the past decade, with genocide and civil wars and creating hundreds of thousands of refugees from numerous countries, including Rwanda, Angola, Sierra Leone, Liberia, the Sudan and Somalia. In 2002 there were 4.2 million people of concern to United Nations High Commission for Refugees (UNHCR) in Africa out of about 20 million worldwide. The Africa figure included 3.6 million refugees, 500 000 internally displaced or recently returned displaced people and 267 000 former refugees who recently returned home (UNHCR, 2002).

According to the recent World Refugee Survey, figures indicate that conflicts in Africa have displaced approximately 13.7 million people in Africa and more than half have fled from the ten largest groups namely; the Democratic Republic of Congo (DRC), Somalia, Burundi Rwanda, Eritrea, Ethiopia, Sudan, Angola Sierra Leon and Liberia (World Refugee Survey, 2003). With these large numbers of refugees and asylum seekers fleeing to other parts of Africa especially South Africa, questions around access to social services such as health are of great concern.

These large continuous flows clearly indicate Africa's continued volatility that has caused refugees to continue to seek asylum in various parts of the continent. Refugees or asylum seekers in Africa are often forced to settle in camps or kept in border areas with major restrictions to their freedom of movement, while some are forcefully repatriated. These restrictions by African states are aimed to restrict refugee flows into their territory. Some observers argue that sizeable numbers of refugees avoid camps and settlements, to the extent that is possible, or use them only as a "safety net" but would finally flee into urban centres and thus become "urban refugees" (Ogata & Kojma, 1995).

With these large flows of refugees and asylum seekers in Africa; Ogata (1995) argues that "urban refugees" have started to appear as people looking for a better living. These large numbers of displaced people who are forced to live in exile due to consequences beyond their control, are grimly accustomed to invectives like "refugee"; "alien"; "parasite" or "flood of immigrants" feasibly could be perceived as threatening and may

trigger for xenophobic attitudes. It is these attitudes that tend to create barriers in accessing social services such as health.

As mentioned, hosting refugees is a relatively new phenomenon for South Africa and there are no refugee camps as a result refugees and asylum seekers are largely self-settled and urban-based. Zotti (1997) highlights that self-settled urban refugees in developing countries face challenges in accessing available health care. He further argues that refugees are particularly vulnerable to diverse health problems because of poor living condition, lack of money and lack of access to proper health care. Palmary (2002) argues that it is assumed that refugees and asylum seekers will assimilate into South African society and access social services in the same way as nationals, unlike in a camp-based situation. Although one of UNCHR's durable solutions to refugee issues is assimilation or integration into the host society, this (assumption of integration or assimilation) does not correspond with the experiences of refugees and asylum seekers in South Africa in accessing social services and health care due to the existence of certain barriers.

2.2 Significance of accessing health care

Access to health services is a global issue. The World Health Organisation (WHO) is a global health agency that advocates equal access to health for all in all countries. The WHO's campaign "*Health for All*" (HFA) by the Year 2000, represented a commitment to an inclusive goal for improvements in health, both nationally and globally (Moran & Simpkin, 2000).

trigger for xenophobic attitudes. It is these attitudes that tend to create barriers in accessing social services such as health.

As mentioned, hosting refugees is a relatively new phenomenon for South Africa and there are no refugee camps as a result refugees and asylum seekers are largely self-settled and urban-based. Zotti (1997) highlights that self-settled urban refugees in developing countries face challenges in accessing available health care. He further argues that refugees are particularly vulnerable to diverse health problems because of poor living condition, lack of money and lack of access to proper health care. Palmary (2002) argues that it is assumed that refugees and asylum seekers will assimilate into South African society and access social services in the same way as nationals, unlike in a camp-based situation. Although one of UNCHR's durable solutions to refugee issues is assimilation or integration into the host society, this (assumption of integration or assimilation) does not correspond with the experiences of refugees and asylum seekers in South Africa in accessing social services and health care due to the existence of certain barriers.

2.2 Significance of accessing health care

Access to health services is a global issue. The World Health Organisation (WHO) is a global health agency that advocates equal access to health for all in all countries. The WHO's campaign "*Health for All*" (HFA) by the Year 2000, represented a commitment to an inclusive goal for improvements in health, both nationally and globally (Moran & Simpkin, 2000).

Research shows (see Barnardo's, 2002) that different refugee groups have different health needs but a lack of access is often the most significant health problem. In the case of refugees and asylum seekers in South Africa, accessing health care is still a challenge due to certain barriers that can create and exacerbate both physical and mental health needs, for example, poor housing, anxiety, harassment and xenophobia. This can effectively disempower them from being able to promote their own health and well-being.

Burnett and Peel (2001) show that refugees may have endured a range of traumatic experiences: massacres and threats of massacre, detention, beatings and torture, rape, sexual assault, witnessing death squads and torture of others; being held in siege, destruction of homes, property or forcible eviction, disappearances of family members or friends; being held as hostage, human shields or are victims of landmines injuries. They argue that being exposed to such atrocities undoubtedly poses a threat to the well being of refugees and asylum seekers as evidenced by reports of high levels of mental health problem. It is for this reason that access to health is of significance as the principles of the global health agency, the World Health Organisation (WHO) states that: *"Everyone should have the same opportunity to attain the highest level of health and none should be unduly disadvantaged."* This clearly includes refugee and asylum seeker communities.

Burnett and Peel (2001) further demonstrate that one in six refugees have a physical health problem severe enough to affect their life and two thirds have experienced anxiety

or depression. Levenson & Coker (1999) highlight that people who have been subjected to torture or seen their family and friends tortured require specialist support. In this case

refugees and asylum seekers are victims of such atrocities and gross human violation and undoubtedly need special support. The WHO definition of health clearly indicates "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Scholars concur that health of the mind and body is fundamental to quality of life (Falola, 1992). As the mind and the body cannot be separated, the health of the population should be the corner stone for any society and access is the greatest challenge.

According to Brock (1994), access to health care makes a central component of personal well-being. Brock (1994, p 66) argues that access to health care works firstly, " by preventing or relieving pain, suffering, and disability and avoiding loss of life." Secondly, access to health care can protect or restore" a person's opportunities, that is, array of life plans that is reasonable to pursue within the conditions obtaining in society. Thirdly, health care has the "ability to relieve worry and to enable patients to adjust to their situation by supplying reliable information about their health". Finally, because all humans are subject to disease and die, health care "has special interpersonal significance: it expresses and nurtures bonds of empathy and compassion... and reflects some of [society's] most basic attitudes about what it is to be a member of the human community." From this argument, it is clear that the existing barriers make access to health care difficult and inevitably affect the health status of refugees and asylum seekers in South Africa. In this case it shows that "Health for All" is still not accessible to all.

2.3 State Obligation with regard to health rights in South Africa

South Africa is signatory to the 1951 United Nations Convention, the 1967 Protocol Relating to the Status of Refugees[11] and the 1969 OAU Convention. These conventions bind all member States to provide all the necessary rights to all in the country's borders indiscriminately. In particular, the 1951 Convention consolidates international instruments relating to refugees and provides the most comprehensive codification of the rights of refugees as a vulnerable group on the international level. The 1969 OAU Convention (now the African Union), also binds member States to apply the provisions of the Convention to all refugees without discrimination as to race, religion, nationality, membership of particular social group or political opinion These international instruments complemented by human rights treaties, enshrine a number of principles, including the principle of asylum. The principle of asylum states that everyone facing persecution has the right to seek refuge in other states.[12]

Access to social services in South Africa has been a source of controversy. The impact of apartheid on health in South Africa has been the focus of numerous studies over the last decade (Kelly, 1990). Most of these have concentrated on showing racial inequalities in the provision of health services. It was during that era that most blacks in South Africa did not have an easy access to health care. All this was the result of discrimination as it

[11] The UN Convention and Protocol Relating to the Status of Refuges defines a Convention refugee as South Africa is among the number of countries that have traditionally provided for the settlement of refugees.

[12] Article 14 of the Universal Declaration on Human Rights.

was in the system. With the advent of democracy, efforts to restructure services for all has been critical priority as the right to health is fundamental to the physical and mental well-being of all individuals and is a necessary condition for the exercise of other human rights[13] including the pursuit of an adequate standard of living.

Domestic Legal Instruments

2.3.1 Provisions of the Constitution of South Africa

Crush; 2001 & Blake; 1998 highlight the fact that South African Constitution has been hailed as the most progressive and inclusive in the world and that the Bill of Rights guarantees unprecedented rights and freedoms and further extends the same rights to everyone living within the boundaries of the national state. For instance, the right to health care services is provided for in the South African Constitution. In other words, the state has a legal obligation to all people living in South Africa to protect their rights. Section 27(1) (a) of the South African Constitution provides for the right of access to health care services including reproductive health care. This clearly means that access to health care services must be provided for on the basis of equality and free from any form of unfair discrimination (Pillay, 1999). Section 27(2) obliges the state to take "reasonable legislative and other measures within its available resources to ensure the progressive realisation of the right." Urban refugees must therefore be afforded equitable access to health services.

[13] *General Comment* No.14 (2000) *The Right to the Highest Attainable Standard of Health*, (Article 12 of the International Covenant of Economic, Social and Cultural Rights)

Furthermore, Section 27(3) provides that no one may be refused emergency medical treatment. The challenge is to define the term "health care services" as used in section 27(1) (a) of the Constitution. This term simply refers to those services that are necessary to ensure a state of complete physical, mental and social well-being.

As socio-economic rights in the South African Constitution have been modelled on the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12 of the ICESCR clearly provides for the "enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity[14]". This means that health care facilities, goods and services have to be available in sufficient quantity; must be physical and economically accessible to everyone, must be ethically and culturally acceptable and must be of a medically appropriate quality[15].

Section 27 of the Constitution makes reference to the right of access to health care services as opposed to health care *per se* (Centre for Human Rights, 2000). The terminology refers to an obligation on the part of the state to create an enabling environment by providing conditions for the individual to realise their rights as opposed to the state necessarily providing free health care on demand to everyone. The right of access to health care services accordingly refers to an obligation on the part of the state to make necessary health care services accessible and available to individuals.

[14]The steps to be taken by State Parties to the ICESCR to achieve the full realisation of the right to health.
[15] *General Comment* No 14 of Committee of ESCR, 2000 Para 12

According to section 7(2) of the Constitution the State has an obligation to respect, protect, promote and fulfil the right of access to health care services. The obligation to respect the right obliges the state to take positive measures so as to ensure that people who do not currently enjoy access to health care services is granted essential levels of health care. Health facilities, goods and services have to be accessed to everyone without discrimination. This includes physical accessibility, economic accessibility (affordability) and information accessibility (Pillay, 2000). In other words, health care services should be available to all on non-discriminatory basis, especially for vulnerable or marginalized groups. When refugees and asylum seekers in South Africa are denied access to health care services, their constitutionally protected rights are being violated. The state fails to promote this awareness to the social service providers (Centre for Human Rights, 2000).

However, in spite of these constitutional rights, the reality remains that many people, including large numbers of refugees and asylum seekers are denied access to health care services or receive compromised access to these services as a result of certain barriers. Refugees, asylum seekers and other vulnerable groups such as the poor face barriers to access health care due to hurdles such as language, ignorance or lack of knowledge or discrimination or socio-economic status.

2.3.2 The Refugees Act 1998

The Refugees Act was passed in 1998. The Act provides specifically for the needs of forcibly displaced persons (Palmary, 2002). Like the Constitution of South Africa, the Refugees Act 1998 states that refugees are entitled to all the rights enshrined in the Bill of

Rights and is very explicit on the access of refugee to basic health care. In this regard Palmary argues that little is said about the potential barriers that exist to refugees accessing local services in spite of the enabling legislation being in place. It is from this perspective that observations with regard to refugees' access to health care have been made.

The Constitution of South Africa clearly defines terms the right to access to "everyone". This includes refugees and asylum seekers. The Refugee Act only stipulates refugees' entitlement to access health care but is unclear with regard to asylum seekers. For instance, the Act states that a refugee " is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time."[16]

Despite some controversy over the inclusivity of "everyone" the Constitution is quiet clear in terms of its universality. The core argument remains that the right to access health care services ought to refer to an obligation of the state.

2.4 Possible Hindrances for Service Access

2.4 .1 Language

According to Omorodion and White (2000), language is fundamental to effective communication and integration into the mainstream society. Blackburn (1991) highlights that social services fail to take into account the needs of this marginalized group.

[16] Refugee Act, No.130, 1998 -Rights and Obligations of Refugees, Protection and General Rights of Refugees, Section 27(g).

Language, as a medium of communication can be portrayed as yet another possible barrier for refugees and asylum seekers to access health care. A study done by the British

Medical Association in 2000 (BMA)[17] showed that the most important barrier to accessing health care services is language. For South Africa the situation is similar because a large number of refugees and asylum seekers come from war torn countries as the DRC, Rwanda, Burundi and Angola. Other countries represented in the refugee population include Congo Brazzaville, Zimbabwe, Cameroon, Ethiopia, Somalia, Eritrea and Pakistan. Most people from these countries do not speak languages that would enable them to access health care.

In this scenario it is clear that language can be a barrier and may make the life of refugees very difficult to deal with the day-to-day problems comfortably. Some studies have shown that language is often cited as a vehicle for the expression of discrimination. This is evident to the study on refugee women in the Netherlands whereby language was the barrier and an instrument of discrimination. In this study, the refugee women were discriminated against especially in antenatal classes because they could not communicate in Dutch (Ascoly & van Halsema, 2001). This situation is very common in most refugee communities as they may not be familiar with the languages in the country of asylum and communicating in an unfamiliar language becomes an obstacle as a result are easily discriminated against. Fassil (2000) conform that language barriers pose the single

[17] "Asylum seekers: meeting their health care needs". Research conducted by the British Medical Association (BMA) in 2000.

biggest problem for the refugees and asylum seekers[18]. It is for this reason that Ascoly, van Halmsema & Keysers (2001) also concur that communication is the key ingredient in the development of the social and support networks that are crucial in helping refugees adapt to their surroundings and navigate their way through the health care system.

Illustrating the difficulty in accessing social services in South Africa, a study conducted by the Community Agency for Social Enquiry (CASE) in 2001, revealed that language barriers were one of the key problems, and health providers tended to become impatient when communication was unclear, resulting in them not attending to the patient. These difficulties were only exaggerated by a high level of ignorance among health personnel who often failed to differentiate groups of foreigners in hospitals and failed to acknowledge their rights with regard to accessing health care (CASE, 2001).

Furthermore, Kang, Kahler & Tesar (1998) argue that in as much as language can be a barrier for refugees and asylum seekers in accessing social services, most communities offer English as a Second Language (ESL) classes, and others provide translator services in some settings. However, Downs, Bernstein & Marchese (1997) argue that learning a new culture, means of livelihood, and other new experiences in a refugee's life make learning the language very difficult for many. The difficulty in learning a new language creates a great deal of stress associated with relocation. The Portland Press Herald Writer (2001) concurs that "immigrants who speak limited English have a hard enough time negotiating the simple challenges of their new culture and how hard it must be to face the medical system or social service agencies when they do not speak the language being used by people who make important decisions about their lives". This situation depicts

[18] "Looking after the health of refugees". Research conducted by Fassil in the United Kingdom in 2000.

the true picture of the South African situation where refugees and asylum seekers experience this.

Language barriers affect communication between the health provider and the health seeker. Language is vital because the health seeker must be able to describe their condition to the health providers who in turn should be able to communicate a diagnosis and relate information about preventative measures and other vital information (CASE, 2001). Language can be easily used as an instrument to discriminate against refugees and asylum seekers to access health care as they may not understand and can be ignored or not given the kind of assistance they are entitled to receive. It is for this reason that Carballo & Nerukar (2001) argue that language problems often reinforce stereotypes and prejudices.

On the other hand, South Africans seem not to have language problem as serious as that of refugees and asylum seekers. This is evident by many instances whereby most of them would try to communicate in the dominant languages of South Africa. In most cases they may speak a grammatically wrong language but the health provider can still understand it. In this way, for South Africans language is not a significant barrier in accessing health care unlike with refugees and asylum seekers. In other instances the health provider would still need someone to interpret but in very rare occasion. It is for this reason that Pillay (1999) highlights that due to limited communication between the health provider and the health seeker may lead to certain patients receiving lesser quality health care

services. According to Pillay, this limitation can undoubtedly cause unfair discrimination against those patients who do not speak the dominant language/s of the health provider

2.4. 2 Socio-Economic Status

Another potential barrier to accessing health care of refugees and asylum seekers and South Africans is the socio-economic status. Facione & Facione (1997) argue that access to health care is often discussed in purely economic terms. They further argue that the issue of access is broad and fraught with political, legal, economic and social difficulties.

It is often assumed that migrants are typically poor people moving from poor economic environments, they carry with them the health profile that result from poverty. Their understanding of health comes from having to adapt to poor ecological conditions along with limited possibilities for change and control over their own life (Carballo & Nerukar, 2001).

According to Facione & Facione the inability to afford comprehensive health care is a major barrier to access. This scenario relates well to the experiences of refugees and asylum seekers in South Africa in that most of them are unemployed because of their legal status and cannot afford medical attention. It is in this way that legal factors can relate to economic factors, working to deny services.

Dutton & Levine (1989) argue that socio-economic status has always been linked to health and individuals higher up in the social hierarchy typically enjoy better health than

those below. MacAthur (2002)[19] shows that a widening of the gap between the privileged and the under privileged, "the have and the have-nots", has an effect on health. In this case, refugees and asylum seekers are underprivileged or "the have-nots" and many refugees and asylum seekers struggle to live below the poverty threshold and this has an effect on both their physical and mental health.

Evans (1994) and others have noted that measures of socio-economic status (SES) and or social class have often been found empirically related to (multiple) measures of health status. They further argue that one's place in social hierarchy appears to be a characteristic of individuals; therefore, it is strongly related to health regardless of the health aspect considered or the measure of status used.

In health research, SES has traditionally been measured using income (household or personal), education and occupational prestige. Most forced migrants experience severe changes in socio-economic status in an entirely new context, sometimes moving from lives lived in relative comfort to more difficult situations where poverty an the integral part of their daily lives, again this tends to pose a threat to their health status (Ascoly, van Halsema & Keysers (2001). Agnew (2002) highlights that scholars such as Greaves and Janzen argue that women's health varies depending on their social roles and the socio-economic context such as unemployment, exposure to stressors and availability of socially supportive networks in which they live.

[19] Human and Community Development: Socio-economic Status and Health. Research conducted for the MacArthur Foundation Organisation, in 2002.

This is yet another challenge evident on the part of refugees and asylum seekers in South Africa in that the situation tends to be more complicated in relation to the existing legislation as circumstances do not allow them to work when health care depends almost entirely on whether one can afford the cost. Faced with this situation, refugees and asylum seekers often find themselves in the midst of an interminable wait when their lives are put on "hold" while the legal issues of their cases are decided within the asylum seeking process. It is this "restriction" period that may further have an impact on their health status.

On the other hand, socio-economic profile is also a challenge for South Africans as most of them are unemployed and live under the poverty line. Their situation may be different (from that of refugees and asylum seekers) in that most of this population group may be destitute but may rely on social grants and support schemes. For instance, a survey[20] indicates that 64% of most black people perform unskilled work and unemployment rates are very high. As Health care in South Africa is sharply divided into the private sector, for those who can afford to pay and / or who belong to medical aid schemes, and the public sector for the indigent, it clearly shows that health care services are still geared to the needs of minority of the population. It is for this reason that Sullivan and Deeker (1992) highlight that in most cases public hospitals, clinics and health posts are commonly used by the poor and very often these public institutions are the ones which are under financed and have limited resources, thus providing less than quality service. It is clear that all those who live under the poverty line will continue not afford accessing good health care.

However, even if the Primary Health Care (PHC) approach to delivery of health service is central as was defined in the Declaration of Alma Ata as "essential health care based on practical, scientifically sound and socially acceptable methods and technologically made universally accessible to individuals and families in the community through their full participation and a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination"[21], still there is no doubt that the fundamental principle is that of social and economic justice.

2.4. 3 Xenophobia

The word xenophobia is derived from the Greek words "*xenos*", meaning stranger or foreigner, and "phobia", meaning fear (Shindonda, 2003). The literal meaning of the word suggests that xenophobic people would dislike all foreigners equally, as it is their "foreignness" that makes them objectionable. The Human Rights Watch highlights that since the end of the Cold War era when refugees lost their strategic geo-political significance, there has been a global trend of xenophobia and growing hostility towards refugees and asylum seekers Human Right Watch, (2003). However, the patterns that emerge of the targets involved in the incidents that are attributed to xenophobia manifest themselves differently. For instance, reports of xenophobia in South Africa have been made through abusive statements and unsubstantiated myths about immigrants (Krochmol, 2002; Geddo, 2003). Shindonda (2003) further argues that xenophobia is expressed in different forms, for example the use of derogatory words. For instance, in

[20] http://www.anc.org.za/ancdocs/policy/health.htm
[21] Ibid.

the case of South Africa, words such as "magrigamba", "makwerekwere"[22] are commonly used when referring to refugees, asylum seekers and immigrants. Stolcke (1994) argues that xenophobia as a general sentiment tends to manifests differently depending on who is xenophobic, and who the target is. In the case of South Africa, refugees and asylum seekers are targets and in many instances they become victims of violence and discrimination.

It is argued that (see Geddo, 2003) that xenophobia and related intolerance, marginalization and social exclusion of disadvantaged and vulnerable groups infringes on their human rights and human dignity. Morris, (1998); Harris, (2001); Magardie (2001); Shindonda, (2003) highlight that reported xenophobic attitudes have been translated into violent attacks and most incidents show that the majority of the victims are African immigrants. It is for this reason that that Palmary (2000) argues that this kind of stereotypes seem to be reserved primarily for migrants from other parts of African countries and suggests a "gradation of prejudice", not unlike the racial hierarchies established under apartheid; whereby one's identity (in the case of a refugee) is determined by one's complexion or nationality.

Added to this, Shindonda (2003) opines, "Xenophobia should be better understood as a notion situated within a large range of negative perceptions, attitudes, behaviours, and actions against foreigners". It is from this notion that Margardie (2001) highlights that the problem of providing health care and other social services in an already overstretched

[22] This name is commonly used by South Africans to refer to the languages of non-nationals but now it carries negative connotations of inferiority.

system, in this situation xenophobia manifests itself by creating additional barriers to refugees and asylum seekers to access health care. This is important for this study as it will help determine if xenophobia is the key barrier or other related factors such as language, socio-economic status or ignorance causing social exclusion are possible factors in creating a barrier for asylum seekers and refugees in accessing health care.

As mentioned, the presence of refugees in South Africa is a relatively new experience and consequently, many people do not understand the difference between refugees and other categories of non-nationals, such as immigrants and /or economic migrants. The situation is further exacerbated by the fact that there is often confusion in the minds of people, between foreigners who are in South Africa illegally and refugees. Instead, most of the time terms like "foreigners" or "aliens" and "illegal immigrants" are used interchangeably or in a derogatory manner to describe non-nationals with little regard to their legal status in the country. According to the Roll Back Xenophobia Campaign launched in 1999, this broad generalization does not show proper understanding of the different reasons, rights and plight associated with each group.

According to the BMJ study (2000) in the United Kingdom, health care professionals do not know how best to support the needs of refugees. The study revealed that many General Practitioners (GP's) are confused about refugees' entitlement to health care. In this case, the GP's ignorance of refugee rights created barriers for refugees and asylum seekers to access health care.

There is no doubt that such ignorance, coupled with prejudice towards refugees and asylum seekers has an impact in terms of access to health care. The South African Constitution clearly stipulates, "*right to access for everyone*" which, *inter alia,* with the WHO principle "health for all", means that health care is a social good available to every person without regard to his or her access to resources. According to Geddo (2002) refugees are often confused with economic migrants who abuse the asylum procedure to remain legally in the host country. As a result, they are blamed for competing with the local population for scarce resources. These perceptions breed increasing intolerance and xenophobia. This is important for the study because of the many perceptions that South Africans have towards forced migrants and failing to understand their plight, protect their rights and dignity.

2.4. 4 Social exclusion

Refugees and asylum seekers are a vulnerable group and can be easily socially excluded. May (1998) highlights that many studies have shown that poverty may also involve social exclusion[23] in either an economic dimension (exclusion from the labour market and opportunities to earn income) or a purely social dimension such as exclusion form decision-making, social services and access to community support. It is for this reason that certain groups, including refugees and asylum seekers are arguably at greater risk of social exclusion.

[23]This term is used to refer to disparate group of people living on the margins of the society and in particular without access to the system of social insurance. It is often used interchangeably with other words as a synonym for social segregation, marginalisation or poverty.

Like the poor, refugees tend to be disadvantaged since they are out of their country of origin and often lack access to basic services, legal rights and employment. Invariably, refugees arrive in South Africa without money, food, shelter or family to take care of them. Moran & Simpkin (2000) argue that poverty; unemployment and social exclusion have been identified as specific socio-economic factors affecting health both directly and indirectly because they are all closely linked. In other words, poverty is a cause of ill health.

In the case of refugees and asylum seekers in South Africa, this situation is further worsened by strong feelings of animosity coming from high-ranking government officials and politicians have at times fuelled xenophobic views. For example, the following introductory speech to Parliament given by Mangosuthu Buthelezi, the Minister of Home Affairs stated " if we as South Africans are going to compete for scares resources with millions of aliens who are pouring into South Africa, then we can bid goodbye to our Reconstruction and Development Programme" (Human Rights Watch, 1998). This view shows the kind of hostility that instils xenophobic stereotypes towards refugees and asylum seekers in South Africa. It is for this reason that Palmary (2002) highlights that these attitudes that are translated into behaviours such as unequal service delivery.

Mason et al, (2001), argue that in many instances individuals or groups become more vulnerable to processes of social exclusion when they face social or economic hardships in one or more dimensions of their lives. This is evident to the social status of refugees and asylum seekers in South Africa and thus fall victims of social exclusion. It is social

exclusion or marginalization that establishes the "them and us" principle, which further exacerbates xenophobic attitudes. In this way discrimination and prejudice seem to separate and exclude individuals from society and from many of the benefits of society, such as equitable access to social services like health.

Poor people lack access to power that would enable them to exercise influence over decision-makers. The health of refugees and asylum seekers may be affected by both past and present circumstances including multiple loss and bereavement, loss if identity and status, experience of violence and torture, poor housing, discrimination or exclusion and xenophobia (Burnett & Peel, 2001). It is for this reason that Connelly and Scweiger argue that "cultural bereavement" and coping with "deeply disruptive change" is a widely shared experience of migration. This suggests that refugees and asylum seekers will continue to struggle to improve their health situation because they might feel powerless as they lack social, political and economic equality (Timngum, 2001). In South Africa where refugees have to fend for themselves and struggle to make ends meet, lack of power and being poor can cause inequality which in itself can be a barrier.

The Declaration of Alma-Ata in 1978 affirmed access to basic health care services as a fundamental human right; many people in resource-poor settings still do not have equitable access to basic services.[24] In many places this gap is widening and South Africa is no exception; accessing health care is a problem especially for the poor generally, let alone asylum seekers and refugees.

[24]Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata USSR, 6-12 September 1978.

Nevertheless, various literatures show how most hindrances affect refugees and asylum seekers in accessing health care, social exclusion is a consequent of the other potential barriers. In other words, social exclusion has a greater impact on refugees and asylum seekers as they can be easily excluded from the mainstream because of their nationality.

CHAPTER THREE

METHODOLOGY

Nueman (1997) states that social researchers collect and analyse empirical evidence in order to understand and explain social life. This section will present a discussion of the key research question to be considered in this report and the methodology used to answer it. In particular the key argument and issues raised in the literature review will be contextualised in relation to the research question. Both qualitative and quantitative research strategies were used to investigate issues relating to accessing health care among refugees and asylum seekers in Johannesburg and to evaluate the role of xenophobia in limiting this access. The study analyses refugees, asylum seekers and South Africans various experiences from the stories they told in response to interview questions in relation to accessing health care. The study further makes an analysis of how health care workers xenophobic attitudes may create barriers for refugees and asylum seekers to access health care.

A key objective of the first part of literature review was to locate if the influences of xenophobia create some barriers for refugees and asylum seekers in accessing health care and ascertain if the same barriers hinder South Africans too. While international literature and research can provide valuable insights and guidelines in relation to refugees and asylum seekers access to health care, managing health needs is one area that should be taken into account. The review examined the possible barriers for service access and

variables such as language, socio-economic status, legal status, xenophobia and social exclusion were explored. It is evident from the literature that language may be one of the significant barriers that can be easily used as an instrument of discrimination in accessing health care. Various studies show how language plays a considerable role between the health seeker and the health provider. It also shows how communication barriers can result in frustration between patient and provider, misdiagnosis and misunderstanding.

The second part of the literature review examined yet another potential hindrance in accessing health care. Socio-economic status emerged as one the most dominant barrier for refugees and asylum seekers in South Africa. Considering that most of the refugees and asylum seekers live under the under the poverty line, and also due to their legal status, access to health care stands as a challenges among many. In the case of South Africans, this situation is not different but to a certain extent from what migrants experience. The difference with South Africans is that even if they are unemployed, support systems may make a difference in one-way or the other in as far as their socio-economic status is concerned. Generally, this situation clearly shows that the cost of medical care can be an overwhelming burden, often competing with shelter, food and other immediate needs to the individual and their families.

The third section of the literature began to address the notion of xenophobia and showing how it can be a barrier in accessing health care for refugees and asylum seekers. Numerous researches have shown how xenophobia manifests itself in the South African context. In most cases xenophobic attitudes may emanate from the fact that foreigners

cannot speak the dominant languages of South Africa and can be easily discriminated against. Different views show that xenophobia may also emanate from certain perceptions that the host society have towards foreigners. It is these perceptions that lead to certain generalisation about refugees. This situation shows the misunderstandings most South Africans have about refugees. For instance, refugees and asylum seekers are mostly discriminated against because of those unfounded perceptions and myths about foreigners. It is such attitudes that tend to create barriers to accessing health care.

The final section of the literature review examined the concept of social exclusion. Social exclusion emerged as an integrated theory that is linked to all these other possible barriers refugees and asylum seekers face in accessing health care. With regard to social exclusion, refugees and asylum seekers remain excluded from the mainstream benefits of the society and are prevented in some way form gaining from the general prosperity. Indicators of social exclusion emphasise political, social and economic components of poverty and inequality and this case, refugees and asylum seekers fall within the cracks.

3.1 QUALITATIVE RESEARCH METHOD

Qualitative methods represent a particular tradition in the social sciences that allows researchers to share in the understandings and perceptions of others and to explore how people structure and give meaning to their daily lives (Nueman 2000; Nueman, 1997). Kitts & Roberts (1996, p.37) tell us that qualitative methods "provide a multidimensional view of social situations".

Open -ended interviews

The qualitative method used to collect data for the research was open -ended interviews. Open-ended interviews permit adequate answers to complex issues and unanticipated findings can be discovered. Rubin &Rubin (1995) argue that, "Qualitative interviewing is a versatile approach". Gilligan (1996) asserts that the "language used and the connection made with qualitative interviewing reveal the world that they see and which they act". In other words, the aim of the interviewer is to listen to how people understand and give meaning to the world they live in.

As mentioned the sample group for this study, all interviews lasted between 60-90 minutes. During the interviews with refugees, asylum seekers and South Africans, the researcher posed specific questions that would fall in line with the key themes relating to barriers such as language, socio-economic status, xenophobia and social exclusion to access health care. The respondents had to relay their different experiences in accessing health care. This enabled the researcher to analyse and ascertain if certain barriers affected all the respondents in the same way or differently.

On the other hand, interviews for the health personnel also had specific questions relating specific barriers such as language, socio-economic status, xenophobia and general problems they encounter when they have to render services to refugees and asylum seekers. During the interview they had to identify if the problems they encountered were

the same when assisting South Africans. This interview enabled the researcher to take note of some negative attitudes that could be linked to xenophobia.

Finally, the interviews with the key informants also focused on certain issues related to refugees and asylum seekers accessing health care. These interviews were conducted to provide relevant insight into access to health issues from different viewpoints. This enabled the researcher to eliminate the main barriers that affect nationals and non-nationals in accessing health care. These main barriers were language, socio-economic status and legal status (identification). Although expressed in a subtle manner, the researcher was able to eliminate some the effects of xenophobia among the health care providers.

3.2 QUANTITATIVE RESEARCH METHOD

In this case the broad area generates and uses data with a distinctive quantitative nature. The data (or information) can represent numbers or statistical techniques can be applied (Creswell, 2002). According to Payne (1999) a quantitative approach emphasises coverage and the ability to generalise to large populations. In this study, a data from a survey conducted by the Joburg Project of the School of Forced Migration Studies (FMSP) at the University of the Witwatersrand was used. This was used to provide quantitative analysis on key issues such as language, socio-economic status, and legal status. It is these variables that gave the researcher detailed information that could be used in relation to accessing health care.

The combination of qualitative and quantitative methods in the study of the same phenomenon is useful for validating the findings of the study and also provides different insights into selected subject area (Kitts & Roberts, 1996). Bickman and Rog (1998) state that the combination of the two methods is called triangulation and reduces the risk of regular distortations fundamental in the use of only one method because no method is free from all validity threats. Triangulation is necessary because of the nature of this particular research, which is aimed at investigating the influences of xenophobia in accessing health care for refugees and asylum seekers in Johannesburg.

3.3 RESEARCH AREAS AND SAMPLING

The research was carried out in Johannesburg, specifically in Yeoville, Bertrams, Berea and Mayfair. A significant number of the participants (refugees and asylum seekers) in this study live in those areas (see Appendix J). For this study, 55 interviews were carried out. The sample comprised of 15 refugees and 15 asylum seekers. From the total, a sample of 10 comprised of refugees and asylum seekers from the DRC, Somali and Angola from which 75% were women and 25% men. Among the respondents about 85% were non-English speakers and could also not speak any of the other dominant languages of South Africa. A sample of 6 health personnel (4 nurses and 2 doctors) and 1 key informant (the superintended) were from Johannesburg General Hospital. In addition, a sample of 2 officers and 1 key informant (the director) were from JRS and finally a sample 15 South Africans as a control group.

The participants in the study were identified through convenience sampling using a snowball strategy. Payne (1999) argues that snowball sampling is a simple and cheap method of obtaining information from people who are not easily identified. This relates well in the case of refugees and asylum seekers as some of their legal status could be still pending or is rather "questionable". The researcher made contacts with the Director of JRS and the Manager of the Africa Programme at the CSVR who agreed to facilitate the establishment of contacts with the respondents. The researcher also made contacts with other refugee communities through participating in different workshops organised by the CSVR.

For comparability in the study, a group of South Africans was also used as a control group. This group was essential for the study because it allowed the researcher to identify if South Africans also have problems in accessing health care. The researcher was able to identify this group after conducting short interviews to establish their willingness to participate. The indicators considered specifically for this particular group were one's socio-economic background, language and if they were regular users of the public facilities such as the Hillbrow clinic and Johannesburg General Hospital. Socio-economic variables made the process of interviewing easy because immediately a respondent was identified; the initial interview would be conducted. The questions that emerged during the interviews included: What kind of barriers do they face in accessing health care. Could it be nationality that influences xenophobic attitudes and access to health care? To investigate the influence xenophobia on accessing health care, an interview schedule guide was used. (see Appendix B).

As this study looks at issues around access to health care, health care workers from local health care centres and hospitals were included in the study (see Appendix C). To solicit more information with regard to access to health care and how the administration handles these issues, the Health Superintended of Johannesburg General Hospital was one of the key informants (see Appendix D).

3.4 DATA COLLECTION METHOD

The participants were interviewed by means of interview- schedule with open-ended questions that were specifically designed to elicit the refugees' experiences in accessing health care. The control group was used to ascertain if South Africans also face the same barriers in accessing health care. The open-ended questions give the respondents greater freedom of answering and maintain the flexibility as they provide more information about their experiences. The face-to- face interaction between the interviewee (specifically the refugee communities) and the researcher, helped to build a rapport. This enhanced openness in collecting views and perceptions considering the sensitive nature of the topic. Bernard (2000) argues that the one dominant aspect of successful interviewing is the interviewer's ability to develop rapport with an interview subject.

An interview guide was prepared for the health workers and the key informants. This helps the interviewer to have fairly solid ideas about what they want to uncover during the interview (Paton, 1990). In other words, researchers assume that the questions have been worded in a manner that allows subjects to understand clearly what they are being asked (See Appendix C, D & E).

As the researcher does not speak French, Somali or Portuguese, three research assistants had to be recruited for this study to help the researcher negotiate interviews with the interviewees. Tape recording was also used to record the interviews. This helped create a more natural environment with limited interruptions and capture all the details relevant for the study.

3.5 LIMITATIONS OF STUDY

Every researcher experiences constraints in the research process. It is important to document the problems in order to help all researchers. In this research, the study intended to investigate influences of xenophobia on accessing health care for refugees and asylum seekers in Johannesburg. However, due to time and financial constraints, the findings of the study could be biased or exaggerated either to make things appear better or worse than they are really are. Also due to the small sample the findings could not be representative of the all the different refugee communities in South Africa. This could also apply to the control group, as the sample is too small to be representative of all South Africans who solely rely on public health services.

The following are the problems that were encountered during the research of this study the research:

1) Although most interviews were scheduled at specific times, most respondents had to be visited more than once, as some of them were out running their businesses as street vendors and hawkers.

2) Some respondents refused to be interviewed at the place convenient to the researcher thus the interviews were interrupted by noise of the radio or people talking from the other rooms etc.

3) The researcher had problems conversing in the respondents' language- and the information sounded rather distorted, as the assistant could not speak in short units of speech.

4) In the case of the control group, some respondents were willing to take part in the study but were too eager to access health care and could not pay much attention to the interview session.

5) Some respondents were too sick to respond to the interview questions.

6) Other respondents who use the facility on regular basis, felt they could be victimised by the health provides and not be attended to.

7) Finally, there were instances where there were distractions from certain shortcomings so as to prevent a negative perception that could emerge.

It is for the above reasons, therefore, that the results should be taken as indicative of broader trends and patterns.

3.6 ETHICAL CONSIDERATIONS

Ethics are a matter of being sensitive to the rights of others. A researcher has a duty to act in a professional manner even when the subjects of research are not aware of their rights or ethical issues involved in research. It is also the researcher's responsibility to protect the confidentiality of data and treat all the respondents with dignity to minimize anxiety

or discomfort. In this study, the participants were fully informed about the research and gave their consent willingly. I was careful not to ask questions that would be unnecessarily intrusive. Furthermore, confidentiality was assured to all respondents. This means that no names or other information that could lead to any of the participants being directly identified is presented in the research findings.

In this study, there was a high possibility of discovering discrimination by health care workers or finding myself in a situation where someone might need medical care help urgently or find elements of corruption whereby refugees or asylum seekers would be compelled to offer bribes to access health care. In these situations, I had no capacity to report such matters to the relevant authorities.

The report on the findings of the study will be given to the UNHCR, JRS and to the Refugee Leaders from those communities that took part in the study.

CHAPTER FOUR

PRESENTATION OF FINDINGS

INTRODUCTION

The aim of this study is to investigate issues relating to access health care among refugees and asylum seekers in Johannesburg and to evaluate the role of xenophobia in limiting their access to health care. In order to achieve this aim, fieldwork was undertaken from November 2003 – March 2004.

This chapter summarizes the results of the fieldwork including the findings of the Joburg Project run by the FMSP at the University of the Witwatersrand. The findings will be reflected both qualitatively and quantitatively. These will also be discussed in various themes that will be divided into five sections namely; xenophobia, language, social-economic status, social exclusion and generalisations made about refugees and asylum seekers in South Africa.

Data is usually in the form of words from transcripts, observation and documents. Data analysis increases refinement of concepts, testing and re-testing interpretations (Payne, 1999). The analysis involves four distinct tasks: transcription; preliminary data inspection; content analysis and interpretation.

4.1.1 LANGUAGE AS BARRIER TO ACCESSING HEALTH CARE

The findings from the Joburg Project[25] show that language may be a main barrier because the respondents do not speak any of the dominant languages in South Africa. For instance, the statistics from the survey show that almost 79% from Angola, 64% from the DRC and 61% from Somalia can communicate in English. The percentages may seem high but it is still a barrier for those who cannot communicate in English. In the case of South Africans the situation is different because about 88.2% can communicate in English. Another advantage of this group is that they can also communicate in other dominant languages of South Africa. It is for this reason that the South Africans who were used as a control in this study did not have a language problem as a barrier in accessing health care. Of those refugees and asylum seekers who have children, almost 3% of those children can at least speak one of the dominant languages in South Africa and in this case it is English, isiZulu or Sesotho. It is for this reason that in most cases the children end up translating for their parents because they easily pick the new language quickly.

The findings of this study show how important it is to communicate in a health seeker's language as it bridges the gap between the health seeker and the health provider. Also language helps the health provider to understand the" world" of the health seeker better. In other words, the health providers can more easily empathise with the health seeker if they share a language. Generally, the findings from the survey data show that more than

[25] Human Displacement, Survival and the Politics of Space. A survey conducted by the Forced Migration Studies Programme (FMSP) June 2003, at the University of the Witwatersrand.

half of the respondents interviewed feel that language is the main barrier in South Africa in accessing health care. They feel to earn a better living in South Africa it is important to know how to communicate in English but a substantial number of the respondents feel that it is essential to know one of the dominant African languages. For instance, the results from the survey show that isiZulu is felt by the survey participants to be an important language in South Africa. This is evident by the estimates in the survey where about 41.6% of the respondents from Angola, 42.5% respondents from DRC and 23.7% respondents from Somalia who felt so.

From these findings we can conclude that language barriers within the health system do not allow for full and equal access to health care services as they discriminate unfairly on the on the ground of language. It is for this reason that most of them feel knowing one of the most dominant languages of South Africa is an advantage as it makes life better for them. In this case it shows how language plays a significant role in their life because it can used as instrument of discrimination and create some barriers to accessing social services. This is one main challenge refugees and asylum seekers have to live with in South Africa.

Further findings revealed that the language barrier is a constant frustration for refugees and asylum seekers. Most of the respondents in this study were women; many were mothers or expectant mothers and encountered difficulties when accessing antenatal care. Most women complained that they could not understand the language used during antenatal classes. From the interviews, more than two-thirds felt they were discriminated

against on the basis of language. These are some of the statements made by some respondents that reflect how language can be a barrier and an instrument of discrimination.

> *"I had to take one of the twins to hospital. The child had jaundice. With the sick child they asked me where I was from and why come here if I can't speak Zulu or Sesotho why speak French?"*[26]

> *"I was in labour and when I cried for help, they just ignored me. I was with a friend who speaks English. She tried to call the nurse but the nurse did not come to help me. After a few minutes, I could feel that the baby was coming, the nurse came and was just shouting at me. Then the nurse spoke in a language I didn't understand. She laughed with the other nurse. I felt stupid and helpless"*[27].

Some of the respondents highlighted that they always go to the hospital with a member of the family or someone they know to translate for them because they cannot relate to the health providers in English. They expressed their concern that language differences pose a barrier to even the most basic cultural assessment. Communication between the patient and health provider is difficult when a family member is translating, as there is a possibility of withholding vital information that may be embarrassing to their family member.

[26] Personal Interview with Dorcas, 09/12/2003. (not her real name)
[27] Personal Interview with Glory, 15/12/2003. (not her real name)

"When I go to hospital I always go with someone to translate for me. But I know that if I didn't have someone to help me, I would have problems at the hospital as I have to see the doctor regularly, as you can see that I'm disabled"[28].

"It is difficult because I do not speak English and my daughter must translate for me all the time. Sometimes I feel she is not telling them exactly what I told her because I don't get any better"[29].

It is clear that language can be a barrier in accessing health care and can easily be used as an instrument of discrimination. The study conducted by CASE (2001) indicated that there is little provision at public health facilities for interpreters to address language barriers and that refugee and asylum seekers are turned away from seeking health care. As shown by the anecdotal statements made by the refugees and asylum seekers above the situation has not changed for the better. Refugees and asylum seekers still have the problem of accessing health care due to a language barrier. For instance, in the case where children have to translate for their mothers, the situation puts even more stress on the child and the mother who has to reveal sensitive issues to the child. This denies a patient the right to confidentiality within the family or community. Burnett & Peel (2001); Coker, (2001) argue that using children to interpret may place inappropriate responsibilities on them. They further argue that having an interpreter may result in inaccurate interpreting or incomplete information or have difficulty in articulating the

[28] Personal Interview with Mavis, 15/12/2003. (not her real name)
[29] Personal Interview with Salumie, 15/12/2003. (not her real name)

illnesses especially when sensitive issues such as sexual health, gynaecological problems, sexual violence, or domestic violence need to be discussed.

In relation to the definition of "health care services" given to section 27 (1) (a) of the Constitution of South Africa, Pillay (1999) says, " it is clear that the patient must be able to communicate his or her symptoms, complaints, conditions etc. to the health care professional who must in turn be able to understand the patient. Effective communication is critical for the health care professional to explain preventative measures, make a diagnosis, cure, heal or treat the conditions that threaten or compromise the individual's state of physical, mental or social well-being". In the case of refugees and asylum seekers, it is clear that interpretative services are essential to ensure effective verbal communication between the patient and health care professional.

The findings from the control group were different to that of refugee and asylum seekers most of them did not have problems in accessing health care and they could communicate in at least one of the dominant languages used in South Africa i.e. either English, isiZulu or Sesotho. These are some of the statements they made with regard to the language issues.

> *"I don't have a problem because I speak isiZulu and if a nurse who speaks Sesotho assists me, I try to explain in my poor Sesotho what my problem is and then the nurse would then speak in Zulu to me. I really don't have a problem"*[30]

"The nurse who was assisting me wanted to know which language I understood better, I told her Sesotho and she spoke in Sesotho. I know isiZulu but I was more comfortable with my mother tongue. If you know a language it is easy to get help anywhere[31]*"*

From these statements it is clear that language was not a barrier to access health care for South Africans, as most of them could either relate or had a way to communicate with the health providers in the most dominant languages in South Africa.

On the contrary, findings from the health care providers point of view were claims that they did not encounter any problems in as far as language problems were concerned. They all echoed that they make use of some members of staff who can either speak French or Portuguese. "Language is not a problem because some doctors here at the hospital can communicate in French or Portuguese"[32].

However, the findings show that there is no provision for professional translators in hospitals and clinics as a result some seekers who come from countries like Somalia have to provide their own translators. The findings indicate that the hospital normally utilises some members of staff who can speak those languages that they are not familiar with i.e. French and Portuguese.

---

[30] Personal Interview with Nomalanga, 25/11/2003. (not her real name)
[31] Personal Interview with Dineo, 29/11/2003. (not her real name)
[32] Personal Interviews with hospital staff, 16-19/02/2004.

In the case of South Africans who do not speak either of the dominant languages, the health providers further claimed that there is no language problem. The findings were that the hospital utilises ordinary people who do not have any medical background like the clerks or orderlies.

It is for this reason that Pillay, (1999) highlights that the controversies and difficulties associated with a multi-lingual society, on one hand, and primarily monolingual health system on the other seem to be numerous and complex. The findings clearly revealed that sometimes the health seekers have to struggle when communicating with the health providers or have to reveal their sickness to people who have no medical background. This may easily lead to misinterpretations and thus the health seeker may receive a wrong diagnosis and medication.

4.1.2 SOCIO-ECONOMIC STATUS AS A BARRIER

Socio-economic status (SES) is related to income, education and occupation. This situation is clearly depicted by the findings from the Joburg survey. It shows that about 5% of the respondents (DRC and Angola) are able to raise a monthly household income of R800-1099 and they have to pay for their social services such as rent and water where they live. The survey shows that about 67% (Somalia), 69% (DRC) and 24% (Angola) have to pay between R500-1999. As mentioned most respondents from the DRC and Somalia are unemployed and this has an impact on their health status. Most of the refugees and asylum seekers survive on the charity of organisations such as JRS, which currently operates despite funding cutbacks. This pays for their roof over their heads;

however, the money is still barely enough to enable them to make ends meet. Others rely on their churches but still it is not enough to cover their monthly needs.

The findings from the Joburg Survey show that the socio-economic status can be a barrier in accessing health care in that most of the respondents are unemployed. For instance, estimates from the survey reveal that about 64% from the DRC, 45% from Somalia and 30.3% from Angola have large families nevertheless earn nothing or very little to make a living. Estimates show that 45% of the respondents from the DRC and 8.5% from Somalia. From these estimates, the DRC has the highest percentages if compared with the other refugee communities. With large families to feed and lack of employment, additional stress is placed on their health status.

Considering refugees' and asylum seekers' socio-economic status in relation to what they earn, paying hospital fees seems impossible. But with regard to hospital fee this is what the superintendent had to say:

"Refugees with the correct proof of course will be classified according to income because these patients according to law enjoy the same benefits as South Africans. The classifications would range form H1 where patients pay R35.00, then H2 they are expected to pay R115.00, then those who are classified under P/ PH/ PM/ PP pay R164.00 and then the last classification is Private foreigners whose medical reasons have been approved by clinical executive have to pay R328.00"[33].

With the new internal policy at Johannesburg General Hospital, the asylum seekers seem to be falling through those cracks of the system. From the findings of the study it shows that their access to health care is difficult due to their economic status, as most of them are unemployed or sell in the street and get very little and cannot, therefore, to afford to pay for their health care. It is in this way that their economic status becomes a barrier. For instance, the Superintended further clarified how patients with different medical need were charged:

"With asylum seekers the situation is different in that they have not attained proper refugee status and therefore can't enjoy the same privileges as South African Citizen. These are classified, as PF (Private Foreigner) are required to pay the deposit of R1 800 upfront. This is for an outpatient visit. But if the patient doesn't have that amount of money, and it is an emergency case they are made to sign an acknowledgement of debt and just hope that they will come to clear their debt .For patients who need cardiology services they are expected to pay R125000.00. Patients with cancerous condition have to pay R120 000.00. Then patients for medical cases have to pay R50000.00. Then the routine surgical cases cost R50 000.00 and then all maternity cases cost R15000.00. Since we cannot deny them access to health care, these debts accumulate tremendously as they cannot afford to pay them and this greatly affects the budget and we end up overspending"[34].

[33] Personal Interview with Dr Joy Peele, Superintendent, Johannesburg General Hospital, 19/02/2004.
[34] Ibid.

Klaaren and Rutinwa (2004) highlight that states are required by Article 17[35] to accord to refugees lawfully staying in their territory the most favourable treatment accorded to nationals of the foreign country in the same circumstances, as regards to the right to engage in wage-earning employment. They further argue that restrictive measures imposed on refugees for the protection of national labour market must not be applied to a refugee who has completed three years of residence in the country; or has a spouse possessing the nationality of the country of residence; or has one or more children possessing the nationality of the country of residence. In spite of these rights, socio-economic status is yet another hindrance in accessing health care for many refugees and asylum seekers in Johannesburg Hospital, as most of them are not employed and therefore, cannot afford health care.

The findings in this study show that refugees and asylum seekers are expected to pay a deposit amounting to R1 800 upfront at Out Patient Department (OPD) at Joburg General Hospital.

"I am very sick and cannot go to the hospital because they want me to pay R1 800. I cannot afford that because I'm not working. I just need help. I don't know what to do. I'm waiting for my last day".[36]

The findings show that asylum seekers have great difficulties accessing health care. It is in such cases that asylum seekers fall through the cracks of the system in South Africa

[35] Article 17 of the United Nations Convention.
[36] All asylum seekers interviewed expressed this concern.12/02/2004.

because the Constitution states it very clearly that "everyone" must have a right to access health care. Being denied access to health care is clear violation of the constitutional and human rights.

Williams & Collins (1995) highlight that many studies show poverty has a strong influence on health and use of health care. In other words the SES has a stronger influence on health and access to care. The findings from the survey also show that more that half of the respondents go to the hospital or clinic to seek health care or advice. This means that the use of health care is very high. For instance, of those who responded to the survey 98.9% from Angola, 85.4% from the DRC and 93.2% from Somalia seek health care from the hospital or clinic. By relating this to the findings of the survey, the respondents earn less or next to nothing and cannot afford to pay for health care. In the case of asylum seekers, the R1800 is far more than their monthly income or what they can afford which obviously creates a barrier, as most them are unemployed.

In the findings a surprisingly high number of interviewees indicated that they are denied access to health care because they cannot pay the high tariffs at the hospital. What is striking about these findings is that refugees and asylum seekers accessing health care will continue to be a struggle as their socio-economic status contributes to creating yet another barrier.

The findings further show that JRS the service provider for refugees and asylum seekers has very limited funds and therefore cannot afford the high tariffs at Johannesburg

Hospital. "We have a crisis. There are no funds any more and it is difficult to cover the hospital costs for asylum seekers as they are expected to pay R1 800. With Home Affairs not processing their papers on time, they will continue to suffer because they must produce proof at the hospital. Another problem arises when it is a refugee who needs specialised treatment can be very expensive and as of now we do not know the future of JRS. We have certainly run out of funds."[37]

From these findings asylum seekers will continue to face barriers in accessing health care. With JRS running short of funds is yet another challenge for the refugees and asylum seekers, as they rely on the organisation for their hospital cover. It is for these reasons that most asylum seekers now would seek health care from other hospitals where they are not charged.

However, it is a different situation with the South Africans because they only are charged R 35.00 and raising this amount of money seemed not a problem even with those who are unemployed. "I paid R35 00 because I'm unemployed. But I had to produce proof that I was not working."[38]

As the findings show this amount is affordable unless one had to under go a major operation. But it seemed not to create any barriers in accessing health care.

[37] Personal Interview with the Director of JRS, Wendy, 09/01/2004.
[38] Personal Interview with S'phokazi, 12/01/2004.(not her real name).

4.1. 3 DOCUMENTATION PROBLEM AS A BARRIER

South Africans with a 13-digit bar coded Identity Document (ID) and refugees with a maroon and silver refugee document or refugee status paper are charged only R35 00 depending on their monthly income. But asylum seekers are classified under PF and are charged R1 800, as they have not attained proper status. Whilst the asylum seekers are waiting for status determination by the Department of Home Affairs (DHA), they continue to face difficulties in accessing health care, as they also face challenges in trying to sustain themselves through work opportunities.

ID's is another barrier to accessing health care. This becomes the main problem for access, especially for newly arrivals in the country. The findings in this regard were that some respondents who just arrived in South Africa could not access health care because they did not have identification documents. "I arrived here two days ago and I'm very sick. I have malaria. My brother took me to the hospital but they asked for my paper, yes, for an asylum seeker paper. I told them that I arrived on Saturday and there was no way I could go to Home Affairs. They sent me away. They couldn't help me. Now I'm waiting for my brother to take me there to be able to get my paper."[39] This is another key problem for asylum seekers in general.

This situation makes the life of asylum seekers even more difficult. Without relevant documents required by the hospital, it is impossible to access health care. This is yet another barrier for asylum seekers. This means that health services are provided to refugees and asylum seekers who have official documentation from the (DHA). It can be

concluded that while the status of asylum seekers has not been approved, their health status is in jeopardy.

4.1.4 ATTITUDES OF HEALTH PROVIDERS

As discussed in the literature, xenophobia is on the rise and there is no doubt that an increasing number of refugees and asylum seekers are denied their basic right of access to health care by health providers who, out of prejudice and ignorance, create barriers. "I was not given any medication. They say there is no medicine for foreigners. They say we must go back to our country. We are too many now here."[40]

However, health care providers all affirmed that refugees and asylum seekers must have access The health care providers all affirmed that refugees and asylum seekers must have access to health care. They all echoed that all refugees and asylum seekers have a right to access health as stipulated in the Bill of Rights of the Constitution. "They have a right as the constitution says but in every right there's a responsibility and that is payment. South Africa does not offer free health care. That is why we have free PHC".[41]

Asked about their attitudes towards the health seekers, the health providers felt that the whole community seems not to understand that the hospital only looks at emergency cases. They state that most patients do not want to comply with the regulations and policies of the hospital. Most patients are said to come to the hospital without referral letters from their clinics or come with minor ailments and demand medical attention. It

[39] Personal Interview with Solomon, 12/01/2004. (not his real name)
[40] Personal Interview with Roselyn, 15/12/2003. (not her real name)

was gathered that most people do not utilise their PHC facilities because a registered nurse attends to them. They would rather prefer the hospital where they might be sent back to their clinics because the condition is not regarded as an emergency.

The findings in this regard were that there is under utilisation of clinics that are even closer to where they live and free of charge. Claims were made that most people seem not to understand that the hospital only attends to emergency cases or depending on the condition of the health seeker. It is only after the doctor's assessment that the superintendent will take a decision whether the patient should be treated or not.

The finding generally was that the out patient care is basically the treatment of emergency cases and patients referred from health centres or local clinics. A nurse may provide primary care equivalent to what can be obtained at a district health centre, but such care would carry a high consultation fee to discourage patients from bypassing the health centre.

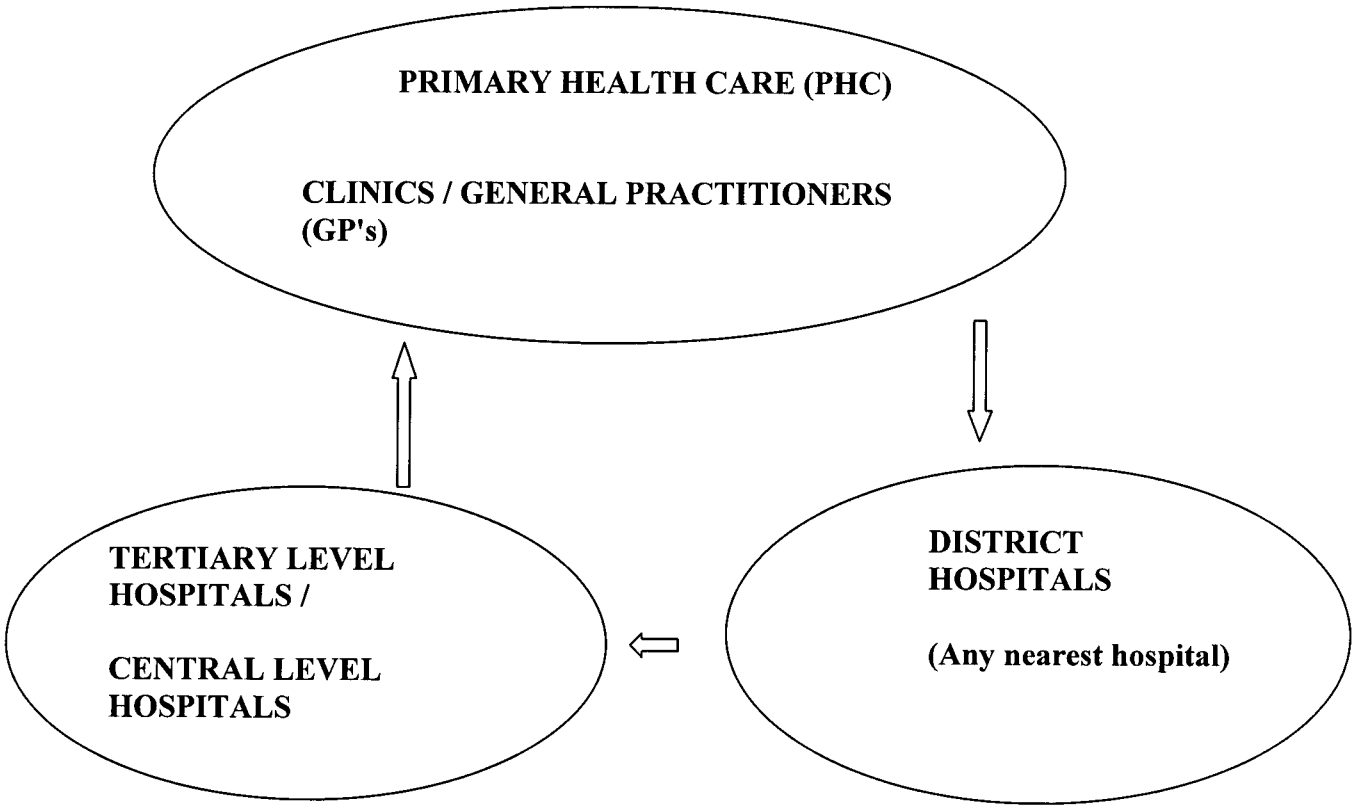
In most instances health providers mentioned misunderstanding, and consequently irritation, as a risk. On the other hand, health seekers feel they are being pushed in directions that they do not want to go in, like being sent back to the clinics. " I was told to go back to Hillbrow clinic. They say this is a minor thing"[42]. Some would see this as a denial of health care they believe they are entitled to. This scenario makes the health providers believe that refugees and asylum seekers are being difficult.

---

[41]Personal Interview with a staff nurse at trauma unit, 20/02/2004.
[42] Personal Interview with Annette, 30/01/2004. (not her real name)

From these findings it is clear that most health seekers are ignorant of how the health care system works as a result most of them are turned away and told to seek help from their nearby clinics or health centres. This situation presents itself as yet another barrier due to lack to information.

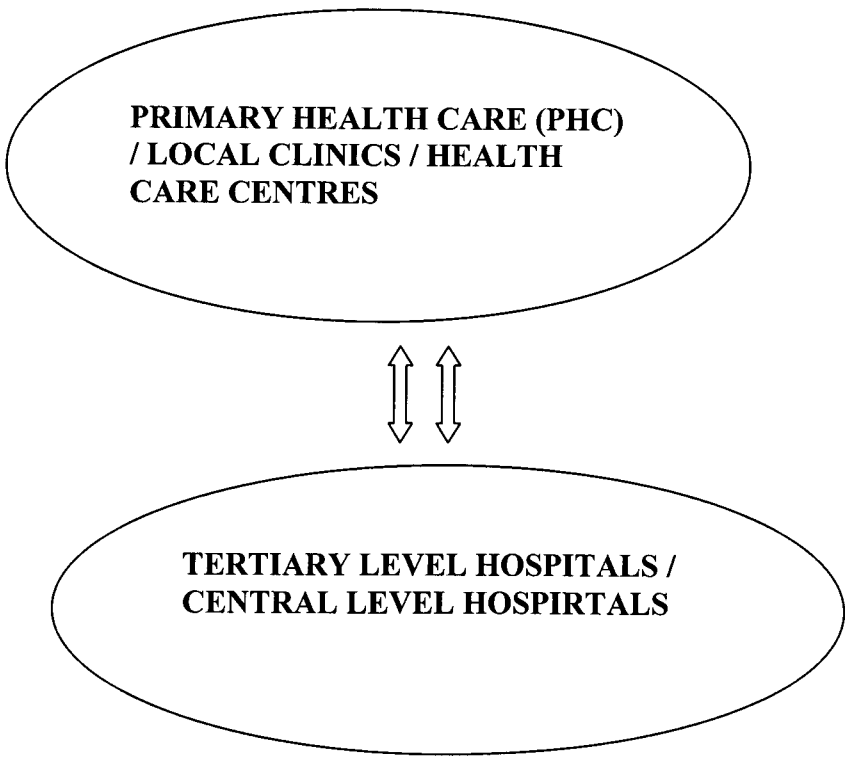
Here below is an illustration of how the health system of South Africa operates.



All health seekers are expected to seek health from their local clinics - Primary Health Care (PHC). If it is an emergency or the condition of the patient is very serious, the patient will be given a referral letter (from the local clinic) to the District Level Hospital.

This is the first level of referral for problems beyond the scope of a clinic or health centre. If the condition of the patient needs the attention of a specialist then the patient can be further transferred to the Tertiary Level Hospital or Central Level Hospital. These are expected to provide technical backup and support. After receiving treatment, the patient will be discharged then advised to go back to the local clinic where the patient will be monitored if needs be.

For expectant mothers the system works differently. As shown below they are expected to go to their local clinics for antenatal care, when it is time to deliver they go to the nearest hospital or District Hospital or Tertiary level Hospital depending on the location. After delivery they will have to utilise their local clinics or health centres to access primary health care for postnatal health care and nutritional services while they are breastfeeding.



With regard to influences of xenophobia as yet another barrier to accessing health care, numerous statements made confirmed the existence of xenophobia in the health care system. For instance, refugees and asylum seekers are said to be having huge needs that are difficult to fulfil and are very demanding. Assumptions were made that refugees and asylum seekers come in large numbers to the hospital and most of them are said to have chronic illnesses and bring more diseases to South Africa. "These foreigners come here in big numbers and are very demanding. Most of them are abusing the already limited health care provision for the local population. We cannot afford the extra load. You see the main worry is that they overcrowd us"[43].

The major finding of the study was that most respondents attributed the "flood" of refugees basically considering the economic aspect as most significant. From these findings there is no doubt that refugees and asylum seekers are still blamed for competing with the local population for scarce resources. This perception is breeding an increasing xenophobic wave among South Africans. The findings for this study also show that sometimes health care providers may harbour stereotypes towards immigrants by labelling them, which may discourage their use of the health service.

The findings show that many refugees and asylum seekers may suffer as a result of ill treatment and insensitivity at the hands of the health providers. For the fact that refugees and asylum seekers are frequently subsumed under the broader category of "foreigner",

[43] Personal Interview with a staff nurse at casualty, 16/02/2004.

they will continue to suffer in the hands of the health providers who seem not to know the difference and in this way making access to health care impossible.

Another striking finding in the study is that all health seekers who are classified as PF are attended after there has been an authorisation and in this case, asylum seekers fall into that category. This means that the life of the health seeker is highly dependent on the decision of that particular person in charge. For instance, in the findings, health seeker X classified under PF was an expectant mother who had some complication and had to be operated and as part of the procedure, she had to be kept hungry for two days. The patient in question was made to wait for more than two days because the clinical executive was attending a series of meetings. As the findings show, before health providers can give any medical attention, there must be some authorisation by the clinical executive. In this case, this is a barrier because the health seeker was not attended to and had to live and seek assistance from another hospital. From the evidence given, it shows that there is violation of human rights as most health seekers are denied access to health care even in dire situations.

From these findings it can be deduced that there are some elements of xenophobia among the health care providers. Again, they all believed that the health providers are very xenophobic and sometimes sent them back without any medication. They all believed that these problems emanate form xenophobic attitudes.

Finally, the findings from South Africans may not be xenophobic but show that the health providers are very unfriendly and very impatient. Health seekers seem to queue for long hours and they are sent form pillar to post. The system is "unfriendly."

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

The aim of the study was to identify the effects of xenophobia on accessing health care for refugees and asylum seekers in Johannesburg. From the findings of the study it can be concluded that there are some barriers that hinder refugees and asylum seekers. The findings revealed the asylum seekers are discriminated against due to language barriers and socio-economic status to accessing health care. Although the findings show that interpreters provided are sometimes "borrowed" from other units, language poses the biggest problem for refugees and asylum seekers. Even in instances where the health seekers would bring their own interpreters who speak minimal English, misinterpretations are likely to occur and sometimes imposing emotional stress on the family member forced into the role of translator. This situation makes the health seekers reluctant to attend follow up visits even if it means preventing future health concerns. Based on the findings, there is need to re-gear communication strategies to rebuild the culture of caring.

Some of the barriers are closely related to an ability to meet refugees' needs, while others are related to attitudes or behaviours within the host society. The attitude of health providers was also identified as a hindrance in the health care services. Most complaints made focused mainly on the negative attitude of health workers. But above all these barriers, social and economic circumstances seem to be the most dominating factor that

cause asylum seekers fall within the cracks. The lack of economic and social support constantly restricts their ability to provide the care expected to them. It is in this regard that Nhlapo (2001) asserts that South Africans are mostly concerned with the economic survival than anything else, and that this causes them to harbour xenophobic tendencies against migrants. It is for this reason that Margardie (2000) espoused that many refugees and asylum seekers are finding a vast chasm between theory and practice of their rights. This stands true in that there seems to be no political will to monitor and implement the health rights of refuges and asylums seekers; what the health providers say is not what they do.

Most comments made by the health providers acknowledged constraints that limit their ability to serve refugee clients. They mentioned that time constraints were a problem in the treatment of pregnant women because translations and specific problems required much extra attention. This presented itself as yet another barrier because they felt that the hospital was understaffed and without enough resources cannot cope with the number of patients they are receiving.

It should be noted that these barriers to accessing health care are not only just experienced by refugees and asylum seekers but by South Africans too. Burnet and Peel highlighted that the basic health needs of refugees and asylum seekers are broadly similar to those of the host population although poor access to health care may worsen one's health condition. For instance, in the case of language, some South Africans may not speak one of the dominant languages and will require access to trained interpreters. As

the findings revealed, some health seekers brought their own interpreters and this clearly denies patients the right to confidentiality. To avoid misinterpretations or incomplete information, trained interpreters are essential to provide valuable information for health care providers on cultural and other relevant issues. There is need to re-gear communication strategies in order to rebuild the culture of caring. It is important, therefore, that every person has the right to achieve optimal health and it is the responsibility of the state to provide the condition to achieve this. It is also the right of all patients to be treated with respect and dignity.

The findings also revealed that xenophobic attitudes towards immigrants emanate from the already "severely stretched health care" and access is difficult, therefore, the current Roll Back Xenophobia Campaign should be intensively directed to all social services officials in contact with refugees and asylum seekers. The campaign should aim at sensitising and create more awareness to all South Africans about the plight and rights of refugees and asylum seekers communities in an effort to combat xenophobia.

International and domestic instruments express the same concern that every person has a right to achieve optimal health and it is the responsibility of the state to provide the condition to achieve this. It is also the right of the patient to be treated with respect and dignity irrespective of one's nationality or socio-economic status. Evidence from this study shows that South Africa has a long way to go to turn the rights in the constitution and the statutes into a lived reality for all.

This study on influences of xenophobia in accessing health care for refugees and asylum seekers has concentrated on their experiences in accessing health care from Johannesburg General Hospital to a lesser extent and not looked at what happens in other hospitals / clinics in Johannesburg. It is necessary that further research should be made in this regard.

BIBLIOGRAPHY

Agnew, V., (2002). "Gender, Migration and Citizenship Resources Project" http://www.collection.nlcbnc.ca/100/200/301/scfc/gender_mi...gender_migration_5_e.htm

Ascoly, N, & van Halsema, I., (2001). "Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands", Journal of Refugee Studies, Vol 14, No 4, pp 382-389.

Baldwin-Ragaven, L, et al. (1999). *An Ambulance of the wrong Colour: Health Profession, Human Rights and Ethics in South Africa*, Cape Town, University of Cape Town Press.

Blake, M, (1998). Rights Up your Street: A Guide to Human Rights in South Africa, Cape Town, National Association of Democratic Layers.

Blackburn, C., (1991). *Poverty and Health: Working with Families*, London, Open University Press.

Bonnerjea, L, (2002). "Shaming The World" http://www.nadir.org/nadir/initiative/linksrhein/archiv/c/000224e.htm.

Brock D.W., (1994). "The President's Commission on the Right to Health Care" in Health Care Reform: A Human Rights Approach (ed) Chapman A., Georgetown University Press, Washington, D.C.

Burnett, A., & Peel, M., BMJ (2001)."Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. http://www.bmj.bmjjournals.com/cgi/content/full/322/7285/544

Carballo, M., & Nerukar, A., "Migration, Refugees and Health Risks"

http://www.cdc.gov/ncidod/eid/vol17no3_supp/carballo.htm

Cars, G., Madinapour, A., Allen, J., (eds) (1998)."Social Exclusion in European Cities", in Social Exclusion in European Cities: Processes, Experiences and Responses, Jessica Kingsley Publishers, London.

Chetty, S., (2000). "Facing Refugees Issues" http://www,queensu.ca/samp/micdocs/Issues.htm.

Crush, J., "Immigration, Xenophobia and Human Rights in South Africa". http://www.queensu.ca/samp/pulications/policyseries/policy22.htm.

Colson, E., (2003)."Forced Migration and the Anthropological Response", Journal of Refugee Studies, Vol.16, No1. Oxford University Press.

Community Agency for Enquiry (CASE), (2001). "Realising Rights: The development of health and welfare policies for asylum seekers and refugees in South Africa", Research for the UNHCR.

Coker, E., Bichard, A., Nannipieri, A., Wani, J., "Health education for urban refugees in Cairo: A pilot project with young men from Sierra Leone and Liberia", Conference Paper, January 2003.

Coker, N., (2001)."Asylum seekers' and Refugees' Health Experience" Policy Comment. Health Care UK.

Connolly, G., (2002). "South African Health Care: A System in Transition" http://www.cehat.org/rthc/paper6.htm

Creswell, J.W., (2000). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, Sage, Thousand Oaks.

Croucher, S., (1998). "South Africa's Illegal Aliens: Construction National Boundaries in a Post-apartheid State" Ethnic and Racial Studies 21 in Immigration, Xenophobia and Human Rights in South Africa, (ed) Crush, J., SAMP Migration Policy Series No.22

Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.
http//www/who.int/hpr/archive.docs/almaata.html

Dutton, P. & Levine, M., (1989). *Socio-Economic Status and Health: The Challenge of the Gradient*, London, Macmillan.

Facione, N. C., & Facione, P.A., "Who Gets Seen"
http://www.scu.edu/ethics/publications/iie/v8n2/seen.html

Fassil, Y., (2000). "Looking after the Health of Refugees. BMJ; 321,59.

Geddo, B., (2002). "Durable Solutions to the Refugee Problem: UNHCR'S Regional Strategy for Southern Africa".
http://www.lhr.org.za/projects/refugee/publications/perspectfull/geddo.htm.

Gifford, S. (1986). "Better health for groups at risk special needs or basic rights?" Community Health Studies, Vol x, pp.411-414.

Gilligan, C., (1999). In a different voice: psychological theory ad women's development Harvard University Press, Cambridge MA, USA.184 pp.

Government Gazette. (1998). The Refugees Act of 1998, No. 1558:Government Printers, Pretoria.

Government Gazette. (1997). The Constitution of the Republic of South Africa .Act 108 of 1996.Pretoria.

Gutto, S., (2001). "International Law, the African State and the Refugee Phenomenon: *The Challenges of Forced Migration in Southern Africa*, Majodina Z, (ed) Africa Institute of South Africa, Pretoria.

Hamilton, H.B., (1999). "Refugee Women, UNHCR and the Great Lakes Crisis" http://www.pressroom.com/~hbhamilton.srp.html.

Harris, B., (2002). "Xenophobia: a new pathology of a new South Africa?" http://www.csvr.org/papers/paphar1.htm.

Human Right Watch (1998). "Prohibited Persons" Abuse of Undocumented Migrants, Asylum Seekers and Refugees in South Africa. New York: Author.

Kitts, J., & Roberts, J.H., (1996). *The Health Gap*, International Development Research Centre, Johannesburg.

Krochmal, R, (2001). "The Current Refugee Situation in South Africa: Cause of Concern." http://www.academy.umd.edu/education/South Africa/SA2001/article.krochmal.htm.

Klaaren, J., & Rutinwa, B., "Refugees and Immigration Controls" Unpublished Paper for the Southern African Migration Project.

Lewis, C., Fein, R, Mechanic, D., (1976). *A Right to Health: The Problem of Access to Primary Medical Care,* New York, John Wiley & Sons.

Levenson R., & Coker N., (1999). "The Health Of Refugees": A guide for GP's London. King's Fund.

MacAthur, (2001)."Socio-economic Status and Health".

http://www.macfound.org/resarch/hcb/bcc/socieconomic_status.htm

Mackebach, J.P., Bakker, M.J., Silton, M., & Diderichsen, F., (2002). "Strategies to reduce socio-economic inequalities in health", in Mackenbach, J. & Bakker, M. (eds). *Reducing Inequalities in Health: A European Perspective*, London, Routlegde.

Magardie, K (2000). "New Hope for Asylum Seekers in South Africa". http://www.queensu.ca/samp/migdocs/New.htm

May, J., (1998). *Poverty and Inequality in South Africa*, South Africa.

Majodina, Z., (ed). (2001). *The Challenge of Forced Migration in Southern Africa,* Africa Institute of South Africa, South Africa.

Mann, J.M., et al. (1999). *Health and Human Rights,* London, Routledge.

Mares, P., Henley, A. & Baxter, C., (1985). *Health Care in Multiracial,* Britain, London, Health Education Council.

Mason, T., et al. , (eds). (2001). *Stigma and Social Exclusion in Health Care*, London Routledge.

Mears, C., & Chowdhury, S., (1994). *Health Care for Refugees and Displaced People,* UK, Oxfam.

Nhlapo, G. M., (2002). "A Grounded Theory Investigating into Xenophobia in South Africa" M.A. Thesis, University of the Witwatersrand, Johannesburg.

Ndlovu, L., (1994). Clients' and Provider's Definitions and Perspectives of Quality of Family Planning Services. Papers presented in a workshop on the quality of health care for women in developing countries, 15-17 October, Budapest.

Niraula, B.B., (1994). Use *of Health Services in Hill Villages in Central Nepal*, Health Transition Review, 4 pp151-166.

Nueman, N.D., (1997). *Social Research Methods: Qualitative and Quantitative Approaches,* Ally and Bacon, Massachusetts.

Nueman, W.L., (2000). *Social Research Methods: Qualitative and Quantitative Approaches,* Ally and Bacon, Boston.

Ogata, S., (1995)."Where to Run? Refugees and Population Movement in Changing World"
http://www.nira.go.jp/publ/review/95sring/ogata.html

Omorodion, F., & White, J., (2000). "Women and Post Traumatic Stress Disorder: Moving Research to Policy" A report Conducted under the Auspices of Immigrant, Refugee and Visible Minority Women of Saskatchewan, Provincial, Project # 61.

Palmer, G.R, & Short, S.D., (1989). *Health Care and Public Policy: An Australian Analysis.* Australia Macmillan Education Australia.

Palmary, I., "Refugees, Safety and Xenophobia in South African Cities: The role of local government"
http://www.csvr.org.za/papers/papalm4.htm

Paterson, I., & Judge K., (2002). "Equality of access to health care", *Reducing Inequalities in Health: A European Perspective*, Mackenbach, J. & Bakker, M. (eds), London, Routledge.

Patel, B., "Refugees and Asylum Seekers" Independent Review Service. The Journal - Issue 23.

http://www.irs-review.org.uk/infocent/journals/issue23/jrnl123_2.htm

Patton, Q.N.M (1990). *Qualitative Evaluation and Research Methods*, Sage Publication, London.

Payne, J., (1999). *Researching Health Needs*, Sage Publications Ltd. London.

Pillay, K., "Access to Health Care Services: Language As A Barrier" Socio-economic Project

Reitzes, M., (1998). "Insiders and Outsiders" in Immigration, Xenophobia and Human Rights in South Africa, (ed) Crush, J., SAMP migration Policy Series No.22

Report on the Realisation of Socio-Economic Right (2000). Centre for Human Rights University of Pretoria.

Ricca, S., (1989). *International Migration in Africa: Legal and Administrative Aspects* Geneva, International Labour Office.

Rubin, I., & Rubin, H.J., (1995) *Qualitative Interviewing: The art of hearing data*, Sage, California.

Rutinwa, B., (2001). "International Refugee Policy for the 21st Century: Which Way Forward?" *The Challenge of Forced Migration in Southern Africa,* Majodina Z, (ed), Africa Institute of South Africa, Pretoria.

The Portland Press Herald Writer (2001)." Language barrier stirs complaints" http://www.portland.com/news/immigration/010805language.shtml

Shindonda, H., (2003). "Xenophobia in South Africa and beyond" unpublished Seminar 14, Rand University of South Africa.

Stolcke, V., (1994). "Xenophobia in a European Context"
http://www.navreme.net/xenophobi.htm

Sullivan, E and Deeker, P., (1992). Effective Management in Nursing, Newyork,Addison-Wesley.

Timngum, D.A., (2001). "Socio-economic experience of Francophone and Anglophone refugees in South Africa: a case of Cameroon urban refugees in Johannesburg", MA thesis, University of the Wiwatersrand, Johannesburg.

The Constitution of the Republic of South Africa (1996). Pretoria, Government Printers.
UNCHR Africa Fact Sheet – June 2002

Tshabalala-Msimanga, M., "Four myths about the certificate of need" Opinion, This Day, December 01, 2003.

Tshitereke, C., (1999). Xenophobia and relative deprivation. Crossings, 3 (2).

Vale, P., (2002) "Migration, Xenophobia and Security Making in Post-Apartheid South Africa" Politikon: South African Journal of Political Studies 29(1)

Van Rensburg, H C J., Fourie, and A & Pretorius, E., (1994). *Health Care in South Africa: Structure and Dynamics*, Pretoria. Academia.

Veenstra, G., "Some Classical and Contemporary Theories of Social Inequality"
http://www.ihpr.ubc.ca/seshealth/abstract06.htm

Warner, C., & Fincelescu, L., (2003) "Living with Prejudice- Xenophobia an Race." Agenda 55.

World Refugee Survey Country Reports (2003)
http://www/refugee.org/world/countrypt/africa/2003/south.africa.cfm
http://www.refugees.org/world/countryindex/congo.kinshasa.cfm

Zotti, M. E. (1997). Public health education for Liberian Refugees Nursing and Health Care Perspectives.20 (6): 302-306.

1951 UN Convention, Convention and Protocol Relating to the Status of Refugees, UNHCR.

1969 OAU Convention, Convention Governing the Specific Aspects of Refugee problems in Africa.

APPENDIX A

Interview Guide for the refugees / asylum seekers in J.H.B

1. DEMOGRAPHICS

1.1 Sex of the respondent

i) Male.....

ii) Female.....

1.2 How old are you?..... .

1.3.How many children do you have?.....

1.4.How old are they?.....

1.5 When did you come to South Africa?.....

SOCIO-ECONOMIC STATUS

2.1 Where do you live?.....

2.2 What type of housing / accommodation do you live in?.....

2.3 How many rooms do you have in the house?.....

2.4 How many people are you sharing the house / room you are living in?.....

2.5 Do you own the place?.....

If no, approximately how much is your rent for the house/ accommodation?.....

2.6 Do you own any property in South Africa? .....

If yes, please specify.....

.....

2.7 Are you working?.....

If you are not working, briefly tell me what you do for a living?.....

If yes, what is your estimated weekly / monthly income? (R).....

2.8 Approximately how much do you spend on food, clothing and other essentials?

.....

2.9 Do you save some money for any emergency purposes? .....

If no, what do you do if you fall sick or a member of your family falls sick?

.....

.....

If you are not working, briefly tell me what you do for a living?.....

.....

3. LANGUAGE ISSUES

3.1 What is your home language / mother tongue?.....

3.2 What other language / languages do you speak?.....

3.3 Do you speak a little of one of the indigenous languages in South Africa i.e. isiZulu, Sesotho, etc.? .....

3.4 When you are at the clinic / hospital do you have problems when you communicate with the health personnel? .....

If yes, what problems are they?.....

.....

.....

3.5 Have you ever been denied access to health care because of language problem?.....

If yes, can you explain?.....

.....

.....

.....

.....

3.6 Do you think language is the main barrier for refugees / asylum seekers to access health care? .....

If yes, can you explain? .....

.....

.....

.....

4. REFUGEE /ASYLUM SEEKERS EXPERIENCES

4.1Do you have the legal documents i.e. refugee status permit / asylum seekers permit?.....

4.2 Have you ever been ill since you lived in South Africa?.....

If yes, where do you go to get medical attention?.....

If no, has anyone in your household been ill since you lived in South Africa?.....

If yes, how do you get medical attention?.....

.....

4.3 How much do you pay for hospital fee?.....

4.4 Have you ever had problems in accessing health care in a clinic / hospital in South Africa because of not having legal documents i.e. refugee permit / asylum seeker permit?

.....

If yes, can you briefly explain what happened?.....

.....

.....

4.5 Every time you are at the clinic / hospital, how would you describe the attitudes of the health personnel towards you as a refugee / asylum seeker?.....

.....

.....

.....

4.6 As a refugee / asylum seeker do you think you have a right to access health care in South Africa?.....

If yes, please explain how you know that.....

.....

.....

4.7 Do you know of any policy in South Africa that clearly stipulates the rights to access health care?.....

If yes, can you explain which one and what briefly does it say?.....

.....

.....

4.8 Generally, what do you think are the main problems at this clinic / hospital in as far as access to health care for refugees / asylum is concerned?.....

.....

.....

4.9 What would you recommend to make access to health for all possible? .....

.....

.....

.....

.....

APPENDIX B

Interview Guide for South Africans in J.H.B (control group)

1. DEMOGRAPHICS

1.1 Sex of respondent

i) Male.....

ii) Female.....

1.2 How old are you?.....

1.3 How many children do you have? .....

1.4 How old are they? .....

1.5 Do you have an I.D? .....

2. SOCIO-ECONOMIC-STATUS

2.1 Where do you live? .....

2.2 What type of housing / accommodation do you live in? .....

2.3 How many rooms do you have in the house? .....

2.4 How many people are you sharing the house / room with? .....

2.5 Do you own the place?.....

If no, approximately how much is your monthly rent for the room/ flat/ house / accommodation?

.....

2.6 Do you own any property?.....

If yes, specify?.....

2.7 Are you working?.....

If yes, what is your weekly / monthly income? (R) .....

If you are not working, briefly tell me what do you for a living? .....

.....

.....

2.8 Approximately how much do you spend on food, clothing and other essentials?

.....

2.9 Do you save some money for emergency purposes?.....

If no, what do you do if you fall sick or someone in your family falls sick?.....

.....

.....

.....

3. LANGUAGE ISSUES

3.1 What is your home language / mother tongue? .....

3.2 What other language / languages do you speak? .....

.....

3.3 When you are at the clinic / hospital, do you have problems when communicating with health personnel?.....

If yes, what problems are they?.....

.....

.....

3.4 Have you ever been denied access to health care because of language problem?

.....

If yes, can you explain?.....

.....

.....

.....

3.5 Do you think language is the main barrier to access health care?.....

If yes, can you explain?.....

.....

.....

.....

.....

4. EXPERIENCES AS A SOUTH AFRICAN

4.1 How often do you go to the clinic / hospital to seek medical attention?.....

4.2 Have you ever experienced some problems in accessing health care?.....

If yes, can you explain?.....

.....

.....

4.3 Has anyone in your family come to the clinic / hospital and was denied access to

health care?.....

If yes, can you explain?.....

.....

.....

4.4 Every time you come to the clinic / hospital how would you describe the attitudes of the health personnel towards you? .....

.....

.....

.....

4.5 What do you think are the main problems in this clinic / hospital in accessing health care?.....

.....

.....

4.6 What would you recommend to make access to health for all possible?.....

.....

.....

.....

APPENDIX C

Interview Guide for the Health Personnel

1. REFUGEES / ASYLUM SEEKERS STATUS

1.1 Do refugees / asylum seekers come to the clinic / hospital?.....

If yes, how often do they come to the clinic / hospital?.....

.....

1.2 From the clinic / hospital records which groups come to the clinic / hospital more often?.....

1.3 Should they produce their legal documents to access health care? .....

If yes, what happens if one does not have the legal documents?.....

.....

.....

1.4 In many instances refugees / asylum seekers have been generally categorized as foreigners as a result high hospital fees which they cannot afford are demanded, and thus may not access health care. Can you briefly explain how you deal with this problem?...

.....

.....

.....

2. LANGUAGE ISSUES

2.1 Would you by any chance know any of the languages spoken by refugees / asylum seekers?.....

If no, do you have interpreters at the clinic / hospital? .....

2.2 How do you communicate with refugees / asylum seekers to understand their health problems?.....

.....

2.3 Language can be the main barrier to access health care , how do you deal with this challenge?.....

.....

.....

3. PROBLEMS TO ACCESS HEALTH CARE (REFUGEES / ASYLUM SEEKERS

3.1 With the influx of refugees / asylum seekers in South Africa, what are your feelings in relation with giving health care to them?.....

.....

3.2 In your view, would you say refugees / asylum seekers are abusing the services?

.....

3.3 With the influx of refugees / asylum seekers in South Africa, what is your view in that social services, especially health are over stretched?.....

.....

.....

3.4 What other problems do you experience when you have to render services to refugees / asylum seekers? .....

.....

.....

3.5 What do you think are the main problems in this clinic / hospital with regard to access to health care?

.....

.....

3.5 Reports have been made that refugees / asylum seekers have been denied health care, yet they have a right to access health care like the nationals, how would you explain this?.

.....

.....

.....

.....

.....

4. PROBLEMS TO ACCESS HEALTH CARE (SOUTH AFRICANS)

4.1 Do you experience the same problems when you have to render service to South Africans?.....

If not, how is it different?.....

.....

.....

If yes, how?.....

4.2 Is there anything else that you think is the main problem in this clinic / hospital in as far as access to health care is concerned for South Africans?.....

.....

.....

4.3 What would you recommend to improve the situation?.....

.....

.....

.....

APPENDIX D

Interview Guide for the Hospital Administrator (key informant)

BARRIERS TO ACCESS HEALTH CARE

1. With the influx of refugees / asylum seekers in South Africa, there seems to be certain barriers for them to access health care, can you explain how that is possible?.....

.....

.....

2. With the influx of refugees / asylum seekers in South Africa, reports have been made that health services have been over stretched in the country, what is your opinion about?

.....

.....

3. As a Health Administrator, has your office ever received any complaints from refugees directly or through refugee advocacy body / bodies or Lawyers for Human Rights on behalf of the refugee communities with regard to access to health care?.....

.....

4. Language has been one of the major barriers to access health care, how has your hospital dealt with this matter? .....

.....

.....

5. Reports have been made with regard to xenophobia / xenophobic attitudes in the health system which creates yet another barrier for refugees / asylum seekers to access health how have you handled that in this hospital?.....

.....

.....

.....

6. I believe *everyone* has a right to access to health care, as stipulated in our Constitution and in the Refugee Act 1998, but with these barriers how can access to <u>all</u> be possible when there are all these barriers.....

.....

.....

.....

7. If you were to change certain things in our health system with regard to access to health care what would you improve? .....

.....

.....

8.What would you recommend that <u>everyone</u> have access to health care?.....

.....

.....

.....

APPENDIX E

Interview Guide for the Service Provider (JRS)

THE ROLE OF JRS AS A SERVICE PROVIDER

1. What are the services that your organisation is currently providing to the refugees / asylum seekers?.....

.....

.....

2. What role does your organisation play in the provision of those services?

.....

.....

.....

3. Do refugees / asylum seekers have problems in accessing health care?.....

.....

.....

4. Can you briefly outline those problems?

.....

.....

.....

5. Have the same problems been reported to your organisation more than once and how

have you addressed them?.....

6. What do you think is the main cause of these problems?.....

.....

7. What would you recommend in order for refugees / asylum seekers not to experience these problems as they have rights to access to health care like the nationals?

.....
.
.....
.
.....
.
.....

.....

APPENDIX F

INTERVIEW GUIDE TRANSLATED INTO SOMALI

Tusaha wareysiga ee qaxootiga / magan-gelya-doonka

1.TIRAKOOBKA DADKA

1.1 Nooca qofka la wareystay

i) Lab .....

ii) Dheddig .....

1.2 Meeqa jir baa tahay / da'daadu waa imisa .....

1.3 Meeqa carruur ah baad leedahay / carruurtaadu waa imisa .....

1.4 Meeqa jirro weeye Da'doodu waa imisa .....

1.5 Goorma ayaad South Africa timid .....

2. HEERKA DHAQAALAHA DADKA

2.1 Xagge ku nooshahay / xaggee degan tahay .....

2.2 Guri / hoy noocee ah baad ku nooshayhay .....

2.3 Guriga meeqa qol baad ku haysataa / gurgaagu waa imisa qol .....

2.4 Meeqa qof baad ku wadaagtaaan guriga / qolka aand ku nooshahay .....

2.5 Meesha Guriga ma adigaa iska leh .....

haddii ay maya tahay, ugu dhowaan waa imisa kiradaada gurigu / hoygu .....

2.6 Wax hanti ah ma ku leedahay South Africa .....

Haddii ay haa tahay, fadlan caddee .....

2.7 Ma shaqaysaa .....

Haddii aanad shaqaynin, si faahfaahsan iigu sheeg waxaad samayso si aad u noolato.....

Haddii ay haa tahay, qiyaastii meeqa ayaa ku soo gasha Usbuucii / Bishii .....

2.8 Ugu dhowaan meeqaad ku bixisaa / qarash garaysaa Cunto, Dhar, iyo waxyaalaha kale ee lagama maarmaanka ah .....

2.9 Wax lacag ah ma u dhigataa arrikasta oo degdeg ah .....

Hadday maya tahay, maxaad samaysaa / suubisaa haddaad jiro uso dhacdo / jirrato am qof qoyskaaga ka tirsan jirro u soo dhca / jirrado.....

Haddii aanaad shaqaynin, si faahfaahsan iigu sheeg waxaad samays si aad u noolaato.....

.....

3. ARRIMAHA LUQADDA

3.1 Waa maxay waddankaaaga luqaddisu / afka hooyo .....

3.2 Maxaad luqad / luqado kale ku hadashaa .....

3.3 Ma ku hashaa waxryana mid ah luqadaha South Africa looga hadlo sida isi Zulu, Sesotho iwm.....

3.4 Markaad tagto Bukaan- socod / Cusbataal dhibaato ma kala kulantaa markaad la Hadlayso shaqaalaha caafimaadka.....

Haddii ay haa tahay, mzxay yihiin dhibaatooyinku?.....

3.5 Weli ma lagu diidey helitaanka daryeel caafimaad dhibaato luqadeed darted?.....

Haddii ay haa tahay, ma qeexi kartaa?.....

.....

.....

3.6 Ma u malaynaysaaa ludda inay tahay waxa ugu muhiihsan ee hortaagan qaxootiga / magan-gelyo-doonka helitaanka daryeel caafimaad ?.....

Haddii ay haa tahay, ma qeexi kartaa?.....

.....

.....

.....

4. KHIBRADAHA QAXOOTIGA /MAGAN-GELYA-DOONKA

4.1 Ma haysataa dukumentiyada sharciga ah sida Bermidka Istaatuska qaxootiga / Bermika magan-gelyo-doonka?.....

4.2 Weli ma jirratay intii aad ku noolayd South Africa?.....

Haaday haa tahay, mid ka mid ka mid ah qoyskaagu ma jirradey intii aad ku noolaydeen South Africa?.....

Haddii ay haa tahaya, sidee daawayn ugu hesheen.....

.....

4.3 Meeqa ayaad ku bixisaa fiiga Cusbataalka?.....

4.4 Weligaa dhbaato ma kala kulantay helitaanka daryeel caafimaad Bukaan-Socod /Cusbataal SouthAfrica sababtoo ah dukumenti sharci ah oo aanad lahayn awgeed sida bermitka qaxootiga / bemitka magan-gelya-doonkaa?.....

.....

Haddii haa tahay, si faahfaahsan ma u sharxi karta wixii dhacay?.....

.....

.....

4.5 Markasta oo aad Bukaan -socod / Cusbataal tagto sidee ayaad u sharxi layhad dareenka shaqaalaha caafimaadka ee ediga kugu wajahan qaxooti / magan-gelya-doon ahaan?.....

.....

.....

4.6 Qaxooti / magan-gelyo-doon ahaam ma u malaynaysa in aad xaq u leedahay helitaanka daryeel caafimaaad South Africa gudeheeda?.....

Hadii ay tahay haa, fadlan qeex intaad ka ogtahay taas?.....

.....

.....

4.7 Ma ku ogtahay siyaasadda South Africa wax si cad u sheegaya xaq ahaanht helitaan daryeel caafimaad?.....

Haddii ay haa tahay, ma qeexi karta waxa (midda) ay tahay iyo waxa ay faahfafahin ahaan oranayso (leedahay) ?.....

.....

4.8 Guud ahaan, maxaad u filaysaa (filaysaa) inay yihiin dhibaatooyinka ugu muhiimsan ee Bukaan-socokan / Cusbatalkan maadaama in daryeel caafimaad loo helo qaxootiga / magan-gelyo-doonka ay tahay lagama maarmaan?.....

.....

.....

4.9 Maxaad ku talin lahayd si loo suurta galiyo in dhammaan daryeel caafimaad loo

helo?.....

.....

APPENDIX G

INTERVIEW GUIDE TRANSLATED INTO FRENCH

QUESTIONNAIRE D'INTERVIEW / REFUGIES ET DEMANDEURS D'ASILE A JOHANNESBURG

1. IDENTITIES DES SUJETS D'ENQUETE

1.1 Sexe des sujets

i) Mâle .....

ii) Femelle .....

1.2 Quel âge avez-vous? .....

1.3 Combien d'enfants avez-vous? .....

1.4 Quels âges out-ils? .....

1.5 Quand êtes-vous arrivé en Afrique du Sud? .....

2. STATUT SOCIO ECONOMIQUE

2.1 Où habitez--vous? .....

2.2 Avez-vous quel type de logement? .....

2.3 Ta maison contint-elle combien de chambres? .....

2.4 Partagez-vous votre maison / votre chambre avec combien de personnes?.....

2.5 Cette maison / chambre vous appontaient?.....

.....

Sinon, quel montant payez--vous approximativement? .....

2.6 Avez-vous une propriété privée en Afrique du Sud? .....

Si, oui, donnez quelques précisions? .....

.....

2.7 Travoul lez -vous? / Etes vous entrain de travailles? .....

Situ ne travaille pas, dis-moi ce que tu fais pour rire? .....

Si, oui, quel est votre salaire / mensuel? .....

2.8 Combien dépensez-vous approximativement quant à la vêtements et autres?.....

.....

2.9 Prévoyez -vous les imprévus dans votre budget?.....

Si non, que faites-vous lorsque vous-mêmes ou un membre de votre famille tombe

malade?.....

Si vous ne travaillez pas, dites-moi ce que vous faites pour vivre? .....

.....

3. QUESTIONS SUR LES LANGUEAS

3.1 Quelle est votre langue maternelle? .....

3.2 Quelles autres langues parlez-vous? .....

3.3 Parlez-vous un peu quelques langues locales sud-africaines? .....

3.4 Avez-vous de problèmes de communication lorsque vous en contrer le personnel

médical à l'hospital ou à la clinique? .....

.....

Si oui, quels sont as problèmes? .....

3.5 Avez-vous déjà manqué les soins à cause de la langue? .....

Si Oui, expliquez-vous? .....

.....

.....

3.6 Pensez-vous que le problème ai langue soit une barrière / obstacle pour les réfugies / demandeurs d' asile? .....

Si, oui, expliquez-vous? .....

4. EXPERIENCES DES REFUGIES / DEMANDEURS D'ASILE

4.1 Avez-vous un document légal, par exemple un permit (statut) de réfugie ou de demandeur d'asile? .....

4.2 Etes-vous déjà tombé malade en Afrique du Sud? .....

Si oui, ou allez-vous-vous fière soigner? .....

Si vous n'étés jamais tombés, y-atril quelqu'un de votre famille qui l'est depuis qui vous étés Afrique du Sud? .....

.....

Si oui, comment faites -vous pour rencontrer le corps médical? .....

.....

4.3 Combien frais payez -vous à l'hospital? .....

4.4 Avez-vous déjà rencontre de problèmes dans l'accès aux soins médicaux à cause du marque de permis de refuge ou d'asile?.....

Si oui, pouvez-vous expliquer brièvement ce qui vous est déjà arrive? .....

.....

4.5 Lorsque vous allez à l'hôpital / clinique, quelle est l'attitude du personnel de saute en vous un réfugie / un demandeur d'asile? .....

.....

.....

4.6 Comment réfugie / demandeur d'asile, avez-vous droit aux sous médicaux en Afrique du Sud? .....

.....

Si, oui, expliquez vous le savez? .....

.....

4.7 Connaissez-vous une loi sud-africaine en matière d'accès aux soins médicaux?

.....

Si, oui, expliquez laquelle et quelle est contenu? .....

4.8 Généralement, quels sont les principaux problèmes que rencontrent elles réfugiés / demandeurs d'asile dais l' accès sois médicaux? .....

.....

4.9 Quelles sont vos recommandations pour l'accès de tous aux soins de santé? .....

.....

APPENDIX H

INTERVIEW GUIDE TRANSLATED INTO PORTUGUESE

Guião de entrevista para os refugiados/exilados em Johanesburg

1. Aspectos demográficos

1.1 Sexo do respondente

i) Masculino.....

ii) Feminino.....

1.2 Qual é a sua idade?.....

1.3 Quantos filhos tem?.....

1.4 Qual é a idade de cada um dele?.....

1.5 Quando é que chegou na África do Sul? .....

2. Características sócio-económicas

Onde é que vive/mora?

2.1 Que tipo de casa é a sua?.....

2.2 Quantos compartimentos tem a sua casa?.....

2.3 Com quantas pessoas divide a sua casa / apartamento?.....

2.4 A casa é sua ou não?.....

.....

.....

2.5 Possui alguma propriedade na África do Sul?.....

.....

.....

Se sim, por favor, especifique. .....

2.6 Você trabalha (emprego remunerado)?.....

Se não trabalha, resumidamente diga-me o que faz para viver?.....

Se sim, qual é a estimative da sua renda semanal/mensal em rands?.....

2.7 Diga quanto é que gasta aproximadamene em alimentos, vestuário e outras coisas essencias?.....

2.8 Tem algum dinheiro para emergências?.....

Se não, o que é que faz quando um membro de sua família fica doente?.....

.....

Se você não trabalha (emprego remunerado), diga-me, de forma resumida, de que é que vive.....

3. LINGUA

3.1Qual é a sua língua de comunicação em sua casa/língua maternal?

3.2 Que outras línguas fala?.....

3.3Você fala um pouco algumas das línguas nativas da África do Sul por ex. Zulu, Sesotho, etc.?.....

3.3 Quando está no hospital/clínica tem algum problema de comunicação com os provedores de saúde (pessoal de saúde)?.....

.....

Se sim, que tipo de problemas?.....

3.4 Alguma vez já lhe foi recusado uma assistência de saúde por causa de problemas referentes a língua?.....

3.5 Você pensa que a língual de fala é a principal barreira para os refugiados/exila dos no que se refere ao acesso aos serviços clínicos/saúde

Se sim, explique.....

.....

4. Experiência como Refugiado/exilado

4.1Você possui algum documento legal por ex. Estatuto de refugiado/exilado?...

.....

4.2 Já algma vez adoeceu desde que vive na África do Sul?.....

Se sim, onde é que recebeu assistênca médica?.....

.....

Se não, alguém da sua família já esteve doente na África do Sul?.....

.....

.....

Se sim, teve alguma assistência médica?.....

4.3 Quanto é que paga no hospital por uma consulta médica?.....

4.4 Já alguma vez teve problemas de acesso aos cuidados/serviços médidos nos hospitais por causa da falta de documentos legais tais como o *permit* de refugiado ou de exilado?.....

.....

Se sim, pode rapidamente explicar o que aconteceu?.....

4.5 Todas as vezes que você está no hospital/clínica, como poderia descrever as atitudes do pessoal da saúde em relação aos refugiados/exilados?.....

.....

4.6 Como refugiado/exilado você pensa que tem direito ao acesso aos serviços de saúde na África do Sul?.....

Se sim, como é que sabe desse direito?.....

4.7 Conhece a política da saúde sul africana que estipula os direitos de acesso?.....

Se sim, pode-me explicar o que é que ela diz?.....

4.8 Na generalidade, o que é que você pensa que são os principais problemas clínicos/hospitalares em relação ao acesso e cuidados de saúde aos refugiados ou exilados?.....

.....

4.9 O que é que recomendaria por forma a que o acesso seja possível?.....

.....

Private bag X39, Johannesburg 2000,
tel: +27 (0) 11 488 4911. fax: +27 (0) 11 [illegible]
www.johannesburghospital.org

JOHANNESBURG HOSPITAL
SIPHILISA ISIZWE WE CARE

Gauteng Department of Health

Enquiries: Ms. L. Myamyu
Office of the CEO

19 February 2004

Ms. Nomcebo Gugu Nkosi
P O Box 1883
Piet Retief
2370

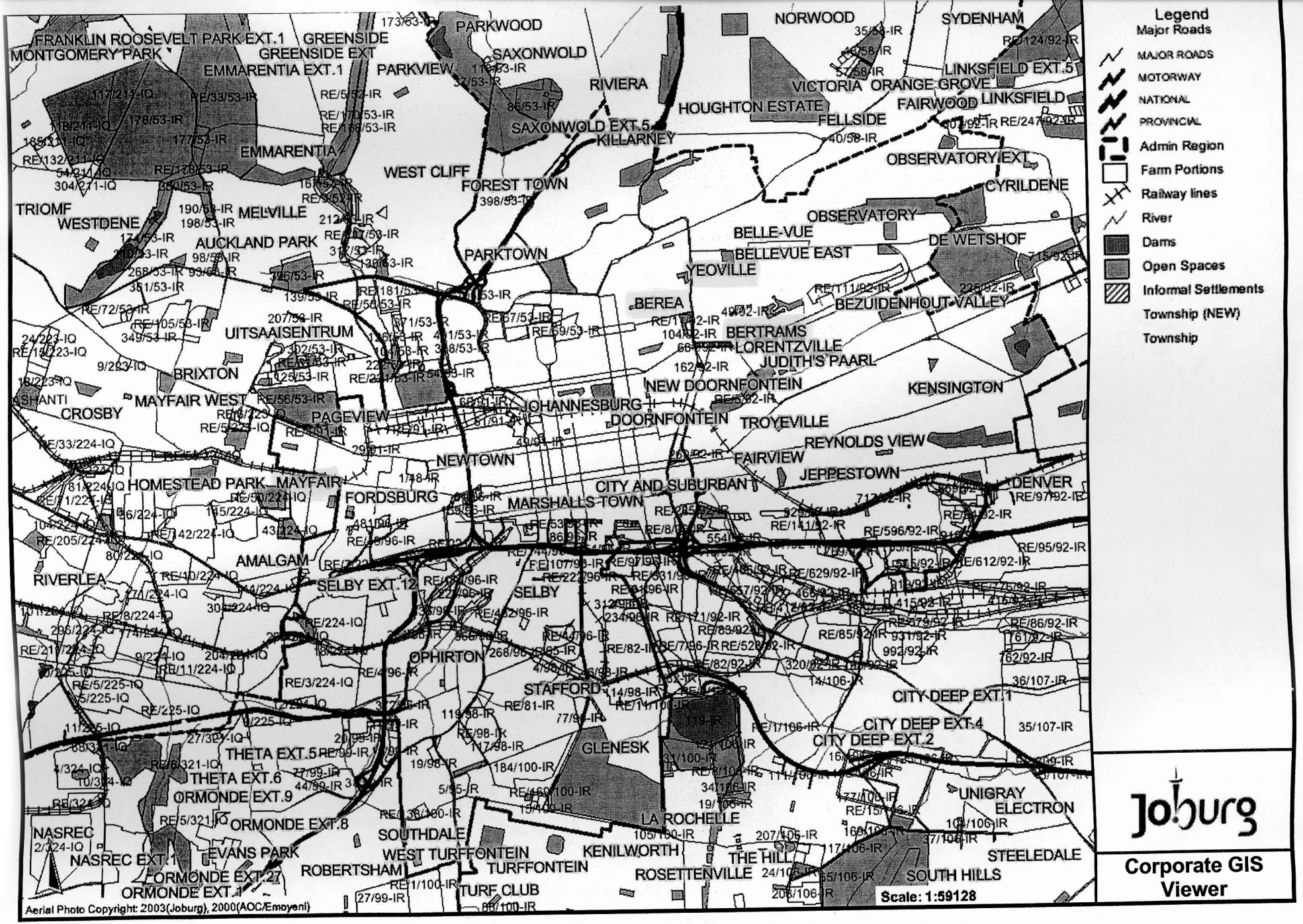
Dear Ms. Nkosi

Re: Permission to conduct **research at Johannesburg** Hospital

This confirms that permission **has been granted that you** conduct a research in the institution. You can interview **healthcare personnel** from the Nursing, medicine and clerical side.

Yours faithfully

Chief Executive Officer


Legend
Major Roads
MAJOR ROADS
MOTORWAY
NATIONAL
PROVINCIAL
Admin Region
Farm Portions
Railway lines
River
Dams
Open Spaces
Informal Settlements
Township (NEW)
Township
Joburg
Corporate GIS Viewer
Scale: 1:59128
Aerial Photo Copyright: 2003(Joburg), 2000(AOC/Emoyeni)
FRANKLIN ROOSEVELT PARK EXT.1
GREENSIDE
MONTGOMERY PARK
GREENSIDE EXT
EMMARENTIA EXT.1
PARKWOOD
SAXONWOLD
PARKVIEW
RIVIERA
NORWOOD
SYDENHAM
LINKSFIELD EXT.5
VICTORIA
ORANGE GROVE
FAIRWOOD
LINKSFIELD
HOUGHTON ESTATE
FELLSIDE
SAXONWOLD EXT.5
KILLARNEY
EMMARENTIA
WEST CLIFF
FOREST TOWN
OBSERVATORY EXT
CYRILDENE
TRIOMF
WESTDENE
MELVILLE
OBSERVATORY
BELLE-VUE
DE WETSHOF
AUCKLAND PARK
PARKTOWN
BELLEVUE EAST
YEOVILLE
BEREA
BEZUIDENHOUT VALLEY
UITSAAISENTRUM
BERTRAMS
LORENTZVILLE
JUDITH'S PAARL
BRIXTON
NEW DOORNFONTEIN
KENSINGTON
SHANTI
MAYFAIR WEST
CROSBY
PAGEVIEW
JOHANNESBURG
DOORNFONTEIN
TROYEVILLE
REYNOLDS VIEW
NEWTOWN
FAIRVIEW
JEPPESTOWN
HOMESTEAD PARK
MAYFAIR
FORDSBURG
MARSHALLS TOWN
CITY AND SUBURBAN
DENVER
AMALGAM
RIVERLEA
SELBY EXT.12
SELBY
OPHIRTON
STAFFORD
CITY DEEP EXT.1
CITY DEEP EXT.4
CITY DEEP EXT.2
THETA EXT.5
THETA EXT.6
GLENESK
ORMONDE EXT.9
UNIGRAY
ELECTRON
ORMONDE EXT.8
LA ROCHELLE
NASREC
SOUTHDALE
NASREC EXT.1
EVANS PARK
WEST TURFFONTEIN
KENILWORTH
THE HILL
STEELEDALE
ROBERTSHAM
TURFFONTEIN
ROSETTENVILLE
SOUTH HILLS
ORMONDE EXT.27
ORMONDE EXT.1
TURF CLUB

APPENDIX J