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KEEPING THE FLAME OF HOPE ALIGHT:

REFUGEES AND RIGHT TO ACCESS TO HEALTHCARE SERVICES IN SOUTH AFRICA

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in partial fulfilment of the requirement for the degree of Masters of Sciences in Medicine in the field of Bioethics and Health law.

Johannesburg, 2010

DECLARATION

I, Catherine Lucy Wambui Githaiga declare that this research report titled:

KEEPING THE FLAME OF HOPE ALIGHT:

REFUGEES AND RIGHT TO ACCESS TO HEALTHCARE SERVICES IN SOUTH AFRICA

is submitted for assessment for Msc Med (Bioethics & Health Law) Course is my unaided work except where I have explicitly indicated otherwise. I have followed the required conventions in referencing the thoughts and ideas of others; it is being submitted for the degree of Msc Med (Bioethics & Health Law), in the University of Witwatersrand, Johannesburg. It has not been submitted before any degree of examination at this or any other university.

Signature 25th February, 2010

DEDICATION

I dedicate this work to my lovely daughter Neema Njeri for her never-ending patience and love, that she has shown me during the study period, when I had to balance between being a mother and a student**.**

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First I would like to thank the Almighty for seeing me through. In addition I would like to thank the following people for their valuable support without which this work would not have been successful. First, to my supervisor Edwin Abuya for his support and expertise that proved to be valuable. Thanks are also due to my faculty supervisor, Professor Donna Knapp van Bogaert for her immense knowledge, my mentor and a source of inspiration. In fact if I were to create my own dictionary the name Professor Donna Knapp van Bogaert would be next to the words 'Supportive and patient'. I am also very grateful to my loving husband, Peter Mbugua who made all this possible, and not to forget my Dad who raised me up to reach for the skies, my late Mother-in-law who taught me to stand up for what I believe in and my entire family back home for their love and support. Lastly but not least, I thank Lorena Nunez and all those who provided their valuable time and input in various ways over the period that preceded the completion of this work.

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LIST OF ACRONYMS

- AALCO - Asian–African Legal Consultative Organization.
- ACHPR - African Charter on Human & Peoples' Rights.
- ACPHR Commission - The African Commission on Human and Peoples' Rights.
- AU - African Union.
- CESCR - Committee on Economic, Social & Cultural Rights.
- CERD - Committee on the Covenant on the Elimination of All Forms of Racial Discrimination.
- COMRSA- Consortium for Refugees and Migrants in South Africa
- CSVR - Centre for the Study of Violence and Reconciliation.
- DOH - Department of Health (South Africa).
- DHA - Department of Home Affairs (South Africa).
- FMS - Forced Migration Studies (Wits).
- HRW - Human Rights Watch
- ICERD - International Covenant on the Elimination of All Forms of Racial Discrimination.
- ICESCR - International Convention on Economic, Social and Cultural Rights.
- ID - Identifying Document.
- ILO - International Labour Organisation.
- LHR - Lawyers for Human Rights.
- MSF - Médecins Sans Frontières
- TAC - Treatment Action Campaign
- MHF- Migrant Health Forum
- UNDHR - Universal Declaration of Human Rights.

- UNDP - United Nation Development Program.
- UNHCR - United Nations High Commissioner for Refugees
- WHO - The World Health Organisation.

KEEPING THE FLAME OF HOPE ALIGHT: REFUGEES AND RIGHT TO ACCESS TO HEALTHCARE SERVICES IN SOUTH AFRICA

PREFACE

During my interaction with various healthcare professionals while pursuing my post graduate degree, it was evident that a number of them were uninformed about refugees' rights.[1] There was a predominant misconception that refugees are a burden to South Africa's already-constrained health care resources. Some of the healthcare professionals that I spoke to pointed out that they would care for all patients regardless of whether they were refugees or not, because they felt that they had a moral obligation to do so and because professional ethics required them to do so. This was the motivation behind my research.[2]

As observed by Bilchitz (2005: 5), the term *'right to health'* is a shorthand expression for two elements; the right to health care and the right to a healthy environment. This research report focuses on the right to health which includes access to healthcare services as one of the components of the right to health. It is not oblivious of other related and interdependent rights and it is not in any way intended to undermine the importance of other rights to health. For the most part, I centre my research report in the context of South Africa.

In line with the above, the research report recognises the fact that the obligation of the states under international law extends to non-state actors. However, this

[1] A *refugee* is defined by the Department of Home Affairs South Africa (2009) as "Anyone fleeing from individual persecution, human rights violations or armed conflict in the land of their origin".
[2] In my further studies, I hope to compliment this research report with empirical research.

research is limited to the state's obligations within the public healthcare sector. The research report takes an entitlement approach because entitlement empowers refugees by:

1. It gives them a base on which to stand up for themselves and for all persons past and present who, in the face of persecution, have become refugees; and
2. It allows refugees to draw attention to and demand the satisfaction of their rights (Liebenberg 2006: 20; Williams 2005: 446);and
3. It uses the legal process in order to obtain the fulfilment of their needs (ibid: 33-34);and
4. It aids in the pursuit of social justice as Pieterse (2006: 447) puts it:

... by demanding the acceleration of structural reforms that would put an end to prevailing hardship and by creating a space for collective mobilisation around such structural reforms.

Although in some instances the research report refers to provisions and studies conducted on foreigners,[3] this study is mainly focused on refugees and asylum seekers. However some of issues affecting foreigners in general inadvertently affect refugees as well.

Overall, my research looks at the general rights of refugees. It acknowledges that there are specific rights that apply to specific classes of refugees.[4] Lastly, the use of

[3] A 'foreigner means an individual who is neither a citizen nor a resident.' (see Yacoob J.'s ruling in Lawyers for Human Rights v Minister of Home Affairs & Another CCT 18/03

[4] These include women and children amongst others. See Convention on the Elimination of all forms of Discrimination Against Women (CEDAW 1979); Convention on the Rights of the Child (CRC, 1989), in article 24 and related regional treaties. Also see s 28 of the RSA Constitution.

the term refugee in the study is intended for convenience and includes asylum seekers.

The main thesis of the study is that states, as promoters and protectors of refugees' right to health, have an obligation to put in place all necessary measures that will aid refugees to full realisation of their right to access healthcare services.

OUTLINE OF CHAPTERS

This research report aims to use international, regional and national laws and literature reviews to reflect on refugees and asylum-seekers rights to access healthcare in South Africa.

In my introductory Chapter 1, I give a brief background on the rights to health in general and in Africa.

In Chapters 2 and 3, I present a reflection on the key obligations placed upon states in regard to this right under international and regional laws respectively.

In Chapter 4, I overview the legal foundation of refugee rights in South Africa.

In Chapter 5, I evaluate the implementation of this right in South Africa and reflect on core challenges that refugees' face in exercising this right.

In Chapter 6, I give a brief overview of some implications that can result if refugees are denied access to healthcare services.

Finally, in Chapter 7 I set out to provide recommendations and conclusions on how this right can be fully converted into an entitlement.

Chapter 1 – Introduction to Refugees Rights

Background

If … socio-economic rights … are to amount to more than paper promises, they must serve as useful tools in enabling people to gain access to the basic social services and resources needed to live a life consistent with human dignity. (Liebenberg: 2002).

Post-apartheid South Africa has become a haven for large numbers of refugees. Many of these refugees have fled from harsh circumstances (e.g. wars, persecution, and famine) which have befallen their native countries. The influx of refugees into South Africa (as opposed to any other African country) is largely based upon two factors. The first factor being the economic success of South Africa and secondly, its human rights based Constitution.[5] In line with the latter, the state has become a party to many international human rights treaties.[6]

In the transition to the "new" South Africa, in 1993 a memorandum of understanding was signed between the South African Government and the United Nations High Commissioner for Refugees (UNHCR) that allowed refugees to enter South Africa. Following the collapse of apartheid, the new South African government repealed

[5] For example, the inclusion of the Bill of Rights in the 1993 Interim Constitution and the current Constitution both provide a clear rights-based agenda. In fact, the South African Constitution has been said to be among the most progressive constitutions in modern society.

[6] In 1994, South Africa signed the International Covenant on Economic Social and Cultural Rights, International Covenant on Civil & Political Rights & International Convention on the Elimination of All Forms of Racial Discrimination; in 1995 it signed Convention on the Elimination of All Forms of Discrimination against Women; and ratified the 1969 and 1951 Conventions as well as the African Charter on Human & Peoples' Rights (in 1996).

apartheid's Alien Control Act 96 of 1991 and enacted the Refugee Act.[7] Since 1994, the South African government has passed almost 200 pieces of legislation concerning refugees and migration. However, the government was slow in re-evaluating the major legislation and the new Immigration Act No. 130 of 2002 was only passed in 2002 (Crush and Williams 2001).

As the South African government's Refugees Act, as well as their related policies, encourages the integration and self reliance of refugees, their health becomes a core factor in successful social amalgamation. The South African Constitution guarantees '*access to healthcare for all'* and everyone has an absolute right to emergency medical treatment.[8] Moreover, under the Refugees Act, legally recognised refugees are entitled to emergency care in the same manner as non-citizens e.g., those with work or study permits.

There is a particular logic in trying to ensure that everyone in South Africa has access to health care as, it will improve the health and welfare of all residents regardless of their nationality (CORMSA 2007:89). Moreover, good health is essential for active engagement in the new South African society. Indeed, health is significantly linked to a decent and dignified life (Taylor 1992: 311).

[7] This was the Refugees Act Number 130 which Parliament assented to on 20 November 1998 and which became effective in 2000. In 2008, this Act was amended as the Refugees Amendment Act (No 33 of 2008).

[8] As articulated in the South African Constitution's Bill of Rights s 27(1):

"*Everyone has the right to have access to - healthcare services, including reproductive health care; sufficient food and water; and Social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. No one may be refused emergency medical treatment*."

The right to health is a product of the twentieth century.[9] It has been broadly attributed to two events:

1) The world-wide depression of 1930; and

2) The atrocities of World War II particularly those of Nazi Germany in the injustices they visited upon Jews.

These factors resulted in the World Health Organization's Constitution of 1946 in which the right to health was affirmed. Before 1946, any state's recognition of a responsibility to their people regarding health was discretionary. [10]

Despite the development of the concept of state responsibility concerning its people's health, the recognition and promotion of these health rights did not happen until late in the 1970's in Africa. The main reason for its late inception was that on attainment of independence African states inherited weak economies and faced difficulties in upholding their state responsibilities.[11]The introduction of socioeconomic rights in Africa can be traced from the Butare Colloquium (1978), which concluded that lack of resources did not justify the lack of respect of human rights (Ouguergouz 2003 : 23-24). This was followed by the Dakar Colloquium (1978) that concluded that human rights could not be reduced to only civil and political rights and therefore the need arose to pay attention to socio-economic rights.

[9] See Robertson (1994:693-714). He observes that socioeconomic rights unlike its counter parts civil rights are a result of recognition in international law of such rights, and then later they were translated in national laws. According to him, this explains the reason for them not been taken to heart by many.

[10] Before the 18th century in the West, diseases were considered as a sign of poverty and immorality and the responsibility for their care was left to families, churches and charitable organisations (Fluss 1997: 376; Chapman 2002: 38). During the 18th century, a shift towards making health a state concern became the norm as Western governments established and administered public institutions for the sick (Fidler 2000). With the industrial revolution came the public health concept. This was a result of the realisation that that poor and unhealthy work and living condition was a cause of illness and the realisation of the need for more productive and reliable force to support industrialisation motivated the assumption.

[11] This was a result of the fact that a large amount of their natural resources had been exploited by their colonial masters with no return to these states in the form of socioeconomic development. The colonial master felt obliged to only maintain law & order. See Oloka-Onyango (1995) 'See R. Oliver & A. Atmore (1994:124)

Following the Dakar Colloquium, the United Nations Human Rights Commission's (UNHRC) efforts to embed human rights (be they civil, economic, political, etc.) were frustrated by the reluctance of African leaders to relinquish their sovereignty to a system of human rights (Nmehiella 2001:70). As result of African leaders' widespread dictatorships in the 1970's, the African Union (AU)[12] saw the need to protect the people and in its 166th ordinary session, it expressed a commitment to the protection of human rights.[13] This lead to the AU adopting the African Charter on Human & Peoples' Rights (ACHPR) in 1981.[14]

From a moral perspective, refugees by virtue of being human, have a birthright to particular rights (such as dignity and worth) and, in keeping with the United Nations Declaration of Human Rights (UNDHR) principles, these rights include the right to health. Likewise, the state has an obligation under the international, regional and national laws to promote, protect and fulfil human rights - including those of refugees. The Vienna World Conference of Human Rights (1993) stated that the commitment by states to protect and promote human rights is 'the first responsibility' of governments. Where functioning healthcare services are reliable, they act as a development marker indicating good health outcomes, as well as pointing to effective engagement with a key state service (Ager and Strang 2008:172). Therefore, any legislation enacted by a state concerning aspects of healthcare e.g. treatment of refugees should be transmitted to those managing and working in the field.

[12] Then known as the Organisation of African Unity (OAU). The Organisation of African Unity was disbanded on July 2002 and was replaced by the African Union, with a vision to accelerate the political and socio-economic integration of the continent.
[13] See AHG/Dec 115 (XVI) Rev I 'Decision on human and people's right in Africa'16th ordinary session of OAU—Monrovia.
[14] Commonly known as 'The Banjul Charter'

Chapter 2 – International Human Rights Standards regarding Refugees

2.1 The 1951 Convention Relating to the Status of Refugees and Protocol 1967 (Protocol relating to the Status of Refugees)

The 1951 Convention and the 1967 Protocol are the two main instruments that specifically provide for the protection of refugee rights under international law. The 1951 Convention consolidated the then-existing international instruments relating to refugees and extended their scope (Weiss 1954: 194). However, the 1951 Convention was designed to redress the refugee problems that existed at the time of its formulation and had geographic limitations in its application.[15] This led to the adoption of the 1967 Protocol relating to the status of refugees (here in after referred to as 'the protocol'). The Protocol was a separate entity; it was not an amendment of the Convention.[16] It lifted all contemporary and geographical limitations.

The purpose of such enactments was and still is to enable persons who no longer have the benefit of protection against persecution in their own country to turn for protection to the international community.[17] For example, in the *Canada v Ward* case[18] the Court observed that;

[15] See Kelly, C. (200: 304). The refugee regime was developed as a response to remedy the European situation of displaced persons due to the two world wars. The regime had a Eurocentric focus. This explains the contemporary and geographical limitation of the convention.
[16] See Weiss, P (1967: 60). See also *Minster for Immigration & Multicultural Affairs v Sarvin (*2000) 171 ALR 483(Ausi. FFC, April. 12,200).The declaration of state parties to the Convention and/or its 1967 protocol, recognised the '*enduring importance of the 1951 Convention, as minimum standards of treatment that apply to persons falling within its scope*.' UN DOC. HCR/mm5p/2001/09, Dec. 13, 2001, Incorporated in Executive Committee of the High commissioner's Program, "Agenda for protection" UN DOC. EC/52/SC/CRP.9/Rev1,June 26, 2002, at part 11, preamble, Para. 2.
[17] This was stated by Lord Hope of Craighead in Horvath vs. Secretary of State for the Home Department [2000]3 ALL ER 577(UK HL, July 6, 2000).
[18] (1993)103 DLR $1h1(Can Sc, June 30, 1993).

International Refugee law was formulated to serve as a background to the protection one expects from the state of which an individual is a national. It was meant to come into play only when the protection is unavailable and then only in certain situations.

2.2 The Link between International Human Rights Law and Refugee Law.

Literature reviews indicate that for a long time refugees were not considered in international human rights. The fact that people are refugees does not make them anything less than human. Refugees are still entitled to human rights as enshrined in the international human rights laws. For example, Zia (Quoted in Harrell-Bond 155: 1986) observes that:

Once an individual, a human being, becomes a refugee, it is as though he has become a member of another race, some subhuman group. You talk of rights of refugees as though human rights did not exist which are broader and more important. We have forgotten that the ultimate recipient of any progress is supposed to be the individual.

In addition there has been a tendency to cluster refugee Conventions under immigration law (Hathaway: 2005, 4). The fact that the refugee international law and human rights international law were developed separately leads many people to conclude that these two are exclusive (Guys 1989: 526). However, this is not the case as the 1951 Convention and its protocol are a branch of international human rights law (Hathaway 2005: 4).

2.3 The Interdependency between Refugee Laws and International Human Rights Regarding Refugee and Health.

The 1951 Convention and its 1967 Protocol provide exceedingly limited protection for refugees (Dunbar-Oritz & Harrel 1987: 107). [19] It does not exhaustively cover all aspects of refugee rights and freedoms. There is no provision for the general right to health. This is because the 1951 Convention provides an alternative or what Hathaway (2005:4) calls a '*surrogate protection of basic human rights'*.[20]

Nowak (1993:95) in his International Covenant on Civil and Political Rights Commentary 95 asserts that the 1951 Convention gives the expression that the rights provided in the Convention are merely a representation of a minimum standard of human rights. Moreover, the accumulation of assorted human rights treaties and domestic laws should not be interpreted to the individual's detriment. In this view, (with regard to the right to access healthcare services) one has to look further at other international human rights instruments so as to "s*ynthesise*" the entitlements of refugees as derived from the Conventional refugee law (Hathaway 2005:7-8). .

The Convention has been greatly criticized because of its geographical limitations. However, although the convention is open to criticism in view of current trends in international human rights law, it represents a starting point for basic refugee protection and the development of other human rights instruments. Hathaway (ibid: 22) strongly feels that this is the case because: most socio-economic rights as

[19] See Hathaway (1999); Millbank (2000)
[20] To Hathaway the fact that the convention is not exhaustive, represents a view of '*an artificially narrow view of the human rights of refugees and should be viewed as a remedial or palliative branch of human rights*' see Hathaway (2005 : 5)

granted in other human rights instruments are subject to fundamental limitations. Hence, subjecting refugees to such limitation serve to deny them subsistence rights.

In addition, the '*substantial formulation of rights under the International Covenant on Economic Social and Cultural Rights* (here in after referred to as 'the ICESCR') *does not provide adequate contextual specificity*' in relation to refugees and hence it does not address the most critical interest of refugees (ibid: 122-123).

How then do we assert this right under the 1951Convention?

2.4 The Rights of Refugees to Health- Interpreting Existing Human Rights Law

Looking into existing refugee rights law; there are interpretations which may lead to the support of refugees and their right to health. Some methods have credence in this regard.[21]

The first is the Purposive approach. This involves interpreting the 1951 Convention in reference to the purpose and objective of the international community. This would be in line with article 31(1) of the Vienna Convention. The Vienna Convention has

[21] The structure of reasoning in human rights interpretation rest on five bases. These are : *textual* or *grammatical* method, which focuses on the treaty text itself as the expression of the common will of the parties; *subjective* or *historical* method, which seeks to extract the "real" intentions of the drafters and, consequently, encourages recourse to *travaux préparatoires*; *contextual* or *systematic* method, which appreciates the meaning of terms in their nearer and wider context; *teleological* or *functional* method, which concentrates on the object and purpose of the treaty and will, if necessary, transcend the confines of the text; and the *logical* method, which favours rational techniques of reasoning and such abstract legal principles as *per analogiam, a contrario*, *contra proferentem. See* Toufayan (2005)

been recognised by International Courts of Justice as a representation of customary rules of treaty interpretation.[22] The article provides that a treaty;

> *Shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in the context and in the light of its object and purpose.*[23]

For example, in an El Salvador case, the Court held that while one must start from the ordinary meaning of the terms used, this should not be done in isolation as there are no ordinary meanings "*in absolute or the abstract*" in treaty interpretation rules. Further, the Court observed that the article refers to "*good faith and ordinary meaning*" so as to give to the treaty terms "*in their context and in light of its object and purpose*".[24]

Therefore, the purpose and object of the international community can be established from the wording of the preamble (Hathaway 2005: 53). The preamble's purpose was to broaden the protection of refugees to the international sphere and

> *... to assure them the widest possible exercise of their rights* ***as enshrined in the main international human rights treaties*** *(Good win-Gill: 2001 emphasis mine).*[25]

It therefore follows that since the ICESCR provides for the right to health and the fact that right to access healthcare services is one of the minimum core obligation

[22] *Kasilikili/ Seduda (Botswana v Namibia)* preliminary objections ,{1996]ICJ Rep 803, at 812: see *Territorial Dispute (Libyan Arab Jama Hiriya v Chad)*, [1994]ICJ Rep 53 at 69

[23] 1969 Vienna Convention On the Law of Treaties: see Good win-Gill, 1996 The refugee in international law, Clarendon press oxford, 2nd ed. P366-8

[24] *Land, Island and Maritime Frontier Dispute (Elvador v Honduras)*, [1992] ICJ Rep 351, at 719(separate opinion of Judge Torres Bernandez, quoted in Hathaway op cit 44.
UN Doc. A/CONF. 39/27 ;

[25] See the preamble to the Convention 1951.

shouldered upon state parties, it can be asserted that this right is amongst the '*widest possible rights'* intended by the International Community.[26]

Secondly, the Non-impairment approach: Article 5 provides that nothing in the Convention shall be deemed to impair any rights and benefits granted by a contracting State to refugees apart from the Convention. It encourages state parties to legislate domestically refugee rights that go beyond the Convention's provisions (Hathaway 2005: 109-117; Nowak 1993: 95)[27].

Hathaway (ibid) observes that article 5 should be read as requiring the governments to respect the array of important international human rights accords negotiated in recent years. In addition he points out that the Covenant envisaged the fact that refugees would be protected by additional rights acquired under other international agreements (ibid: 109). Therefore, article 5 provides a safety net where the Convention is silent on specific aspects that are vital for enhancing refugees' dignity.[28]

From the wording of article 5, it can be construed that the article was a redeeming clause of any oversight that the international community may have had. It can therefore be argued that this article stops states from using the 1951 Convention's shortcomings as means of escaping from their responsibilities towards refugees. These responsibilities would include providing refugees with health care services.

[26] See the preamble to the convention; See J Hathaway (2005:53).
[27] Nowak asserts that "*the saving clause---gives expression to the principle that the right of the covenant merely represent a minimum standard and that the cumulating of various human rights convention, domestic norms and customary law may not be interpreted to the detriment of the individua*l." Nowak, ICCPR Commentary at 95.
[28] For further discussion on article 5 see J. Hathaway, (2005), for example he argues that the development of treaty based system of international law has filled many critical gaps in the Refugee Convention's right regime.

In addition, Hathaway (2005: 106) has argued that although article 2 of the 1951 Convention creates a corresponding obligation on refugees to respect and obey the laws of the host state, it does not create a reciprocal duty on the host state to recognise refugee rights only when they meet their side of the deal.[29]Therefore refugees would be entitled to the right to access healthcare services regardless of whether or not they break the law. [30]

Moreover, the inclusion of the right to work has a positive contribution towards the realisation of the right to access healthcare service in two ways; first employment empowers refugees to purchase healthcare services in situations where public healthcare services are not available to them due to scarcity of resources (such as was the case in Soobramoney case)[31] or where refugees need to pay for state subsidized services. [32]

Secondly, the right to health just like other rights such as property right does not necessary literally mean that state has to provide services free of charge, but to work on the situation that can hinder the full enjoyment of such rights. For example ensuring that all infrastructures that facilitates full realisation are in place and also

[29] In cases where a refugees breaks the laws of the host country, the only redress that such host countries have is to subject him or her to the appropriate sanctions as provided by the county's laws and regulations that are applicable to the citizens. However repeated violations may warrant expulsion, but until then he or she is entitled to enjoyment of the rights guaranteed in the convention. See Mr Hoeg of Denmark, UN DOC. A/CONF.2/SR.4, July 3, 1995 at 4-5

[30] See *Singh v. Minister of Employment & Migration* (1985)1 SCR 177: where the Supreme Court rejected a point of view, that immigration involves notion of privilege and it is therefore an exercise of discretion and not a right.

[31] *Soobramoney V Minister Of Health*, KZN 1998(1) SA 765

[32] See the ILO constitution. It affirms as follows: *All human beings irrespective of race, creed or sex have rights to pursue both their material well-being and their spiritual development in conditions of freedom and dignity of economic security and of equal opportunity* See also All text in Brownie 1. , Basic documents in international law, (3rd ed. 1982).

that qualified personnel are availed to the people, while people pay for this services for example, using the means test used in South Africa.

2.5 The General Provisions of Human Rights Law as They Apply to Refugees

The right to health under the international human rights regime can be first traced to the United Nations Declaration of Human Rights (UNDHR).[33] As a statement of justice, the UNDHR lacks legal force. It is however important as it still seeks to achieve a common standard of good for all people and all nations.[34] Most of its provisions are considered by legal scholars to be a part of customary international law (Leary 1994: 31).

Article 1 of UNDHR establishes the key principles of equality and dignity. These principles are the basis for universal human rights (Mann 1998: 31).[35] By using the language of '*dignity*' article 1 identifies that rights (including the right to health) emerge from the inherent dignity of all humans. The article is focused on human dignity of an individual as opposed to the good of society or societal goods. It can be inferred from article 1 that a human rights approach rejects a utilitarian approach (Leary 1994: 36).Hence any act that interferes with the realisation of refugees entitlement to access to healthcare services would not only be legally wrong but also immoral.

The International Convention on Economic, Social and Cultural Rights (ICESCR), as the major document that specifically provides for socioeconomic rights, provides the

[33] See Article 25 of UNDHR. South Africa is a signatory to this covenant but has not yet ratified it.
[34] See the preamble of the UNDHR
[35] See Mann J.(1998 : 30-38)

normative force of the right to health under article 12.[36] This article has been viewed as possibly the most significant international provision concerning the right to health (Chapman: 2002). Dankwa (1998:544) has also observed that article 12 is an improved version of article 25.[37] This because, by the time state parties were adopting the UNDHR, the general assembly had already instructed the Human Rights Commission to prepare a Convention covering the same provision and therefore the state parties believed that they were not adhering to a document that had a legal force (Gandhi 1998: 239).[38] The UNDHR was meant to act as a safety net while the parties waited.

Important to this research is also article 12 (2) (c) and (d) which sets out specific measures to be taken by states in order to achieve full realisation of the right to health. Under these sub- articles, states are required to take steps which are necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases. They are obliged to create conditions that would assure to all persons that medical service and medical attention are provided in the event of sickness among others. A correct reading of these obligations envisages a situation where the states would avail to the population accessibility to healthcare services. In this regard states are duty-bound to create systems of urgent medical care and they are jointly and severally enjoined to: make available relevant technologies; implement and enhance immunisation programmes (General comment

[36] Other international instrument that have embedded this right are: Convention on the elimination of all forms of discrimination against women (2003) art 4, Convention on the Rights of the Child art 24; and International Convention on the Elimination of All Forms of Racial Discrimination art 5(iv)

[37] Article 25 provides as follows:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

[38] This saw to the enactment of ICESCR In 1966.

14 Para 16)[39]**;** create conditions which would assure to all medical services; and medical attention in the event of sickness.[40]

Article 12 places three duties on state parties. These obligations have been used as interpretive tools and have proven to be a durable means of ascertaining accountability (Dankwa, Flinterman & Leckie 1998: 713).[41] The duties are to: respect, protect and fulfil the right to health. Respect requires states to refrain from adversely interfering with the right to health by denying or limiting equal access to all people to healthcare services (General comment 14 Para 3-4). This is a negative duty. In refugees' case the duty would include not denying refugees access to preventive, curative and palliative healthcare services and censoring, withholding or intentionally misrepresenting information concerning health.[42] Duty to Protect requires states to prevent third party violation of this right. It is therefore recognised that violators of the right to health includes all entities capable of causing harm of the enjoyment of these rights. Third parties include individuals and private entities (Leckie 1998: 108).[43] Therefore this obligation extends to cover states responsibility to regulate third parties behaviours.[44]

Accordingly, state parties to ICSECR are duty-bound to put in place measures that would regulate their citizens' behaviours and altitudes that may negatively impact on

[39] This provision is in line with South Africa constitution provision in s 27(3) which provides for the right of every person to emergency medicine.
[40] See General comment 14 Para 17 which expounds on obligation set on the third measures.
[41] These three duties are commonly known as "typology "of obligation
[42]This would include sexual education and information, as well as not preventing refugees from participation in health-related matters.
[43] See Second Interim report on the question of the impunity of perpetrators of human rights violations, prepared by Mr. El hadji Guisse, special Rapporteur, and UN. ESCOR. Comm'n on Prevention of Discrimination & protection of minorities, 48th sess. Agenda item 8, at 33, UN. Doc. E/CN. 4/sub.2/1996/15(1996)
[44] See Dankwa, Flinterman & Leckie (1998: 714). See also Chapham and Rubio (n.d).

refugees' realisation of their right to access healthcare e.g., xenophobic attitudes and other related intolerance by health staff and others.

The obligation to fulfil involves the state taking affirmative measures to assist individuals and communities in realisation of the right to heath (Ngwena 2005:116).[45] This, in refugee situations, would include for example; legislative implementation of their right, adoption of a national health policy with a detailed plan for realising the refugees right to health; including immunization programmes against the major infectious diseases, and awareness programmes amongst others. These duties should be viewed as rather distinct from general duties towards these rights (Leckie 1998: 91).

2.6 Parameters of the realisation the refugees right to healthcare services.

2.6.1 Progressive Realisation of the Right to Healthcare services

Article 2(1) of the ICESCR provides that state parties should undertake steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights. The Committee on Economic Social and Cultural Rights[46] has observed that this article is essential for the understanding of the nature and extent of states obligations (General comment 3, para 1).[47]

[45]See Gen. Com. 3 Para 36-37.
[46] The CESCR has played a vital role of promoting awareness of right to health and have also been active in interpreting the parameters and terms as provided in the CESCR. See Leckie (1998: 113).
[47] See Article 2 of the CESCR.

The article imposes obligations of conduct and result. The former involves states taking action reasonably calculated to realise the enjoyment of the right to health, while the latter necessitates states to achieve a specified target as a measure of standard of realisation of the right to health.[48]

However states have an appreciable margin of discretion when making choices of what would be the appropriate means of satisfying the right to health (General comment 3 para 4). Though legislation is necessary, it is not a compulsory means of realising rights under ICESCR (General Comment 3 Para. 5 & 7).[49] Therefore states should ensure three essential elements: predictable legal domain which should reflect the demands of these rights as they arise; independent, impartial and accessible judiciary; and targeted, appropriate and effective policies (Leckie 1998: 105).

By subjecting the rights to health to progressive realisation and availability of resources, Article 2(1) reflects on the practical hitches experienced mostly by developing states (Chirwa 2003: 547). It provided a '*the sword of human rights rhetorical'*, and '*a wiggle room for the state*' (Robertson, 1994: 694). Nonetheless the fact that the article introduces the concept of 'progressive realisation' of socioeconomic rights does not denote that these rights can be postponed *ad infinitum* (Limburg principle 21). What is expected of the states is for them to take

[48] See Gen. Com. 3 par. 1; see Maastricht Guidelines On Violations of Economic, Social and Cultural Rights(Developed in 1997 under the auspices of the international commission of jurist and served to elaborate these rights and outline the appropriate &remedies, Maastricht Guidelines On Violations of Economic, Social and Cultural Rights (1998). Leckie (Ibid) points out that these two obligations should be seen as overlapping as they are interrelated and are tool for discerning violations. See S. Leckie (Ibid: 92).

[49] Other measures include; financial, educational, judicial and social: See Limburg principle 18.

targeted, concrete, and transparent steps (General comment 3 Para 2).[50] States are expected to move 'expeditiously and 'effectively' as is possible towards a full realisation of these rights (General comment 3 Para. 9).[51] In addition the guarantee to exercise a right to health must be in line with the principles of availability, accessibility, quality and acceptability.[52]

2.6.2 Minimum Core Obligation.

Flowing from the above concept, General comment 14 introduces the concept of the minimum core obligations (Para. 43).[53] States are expected to satisfy at the lowest possible the minimum basic levels of the right to health regardless of the level of economic development.[54] These core obligations are non-derogable (General comment 14 Para. 47). The reason for the stern approach is that what is required is relatively affordable and does involve a considerable diversion of resources (Dankwa 1998: 717).[55] This ensures priority is given to the contentment of basic needs of the people (Chirwa 2003: 174).

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[50] See Alston & Quinn (1987:166).

[51] Unfortunately the CESCR does not define what amounts to moving '*expeditiously*' and '*effectively*' .see Chapman (1996: 32).

[52] See Cheraw (2003 : 555);Availability infers that relevant goods and services plus programmes be made available in sufficient quantity within the state; quality infers that services and goods must be of good quality &/or scientifically & medically appropriate; acceptability infers that the relevant facilities , good and services are culturally acceptable, gender sensitive &/or ethically appropriate; and accessibility infers that relevant goods and services are accessible in sufficient quality to all within the state party ,physically & economically without discrimination.

[53] See Declaration Alma-Alta adopted by WHO and UNICEF in 1978.it set out inter alia minimum core obligations imposed on the state on the right to health care, which were expanded by Gen.com14. these minimum core include: Ensuring non-discrimination on right to access health facilities, goods and services; providing essential drugs as defined from time to time under WHO Action Programme of Essential Drugs; ensuring equitable distribution of all health facilities & goods & adopting & implementing a national public health strategy & plan of action; on basis of epidemiology evidence; addressing the health concerns of the whole population.

[54]See General Comment 3 Para 10. This points out that the introduction of the minimum core obligation ensures that socioeconomic rights are not interpreted as being ideals to be attained. See Maastricht Guidelines op cit, which has also restated the provisions of General comment 14 Para 47; see Para 9&8. See also 1993 UN Resolution , UN ESCR, commission on Hum Rts./Res.1993/14.

[55] See Ngwena (2005: 117) he observes that this stern approach to core obligation can be ascribed to strong egalitarian ideology focusing on substantive equality and ensuring that the state provide a 'minimum floor' of health services. See also, Progress report of special Rapporteur on Realisation of economic, social & cultural

Important to the issue of refugee's right to access healthcare services, the Maastricht Guidelines stipulates that a state violation of the right to health will occur if a significant number of people are deprived of essential primary health care.[56] Nonetheless the core obligation should be interpreted purposively while taking into account circumstances beyond the state control (Maastricht para. 13). It is upon the state that is unable to meet the minimum core to prove that every effort has been made to prioritise these obligations (General comments 3 Para. 10)[57] .

There have been suggestions that the Committee on Economic Social and Cultural Rights could use the reporting system of the treaties bodies to hold states accountable to the implementation of the UNDP proposed 20/20 agreement. The World Summit for Social Development in Copenhagen 1995 adopted the UNDP proposed 20/20 compact for human development. It calls for 20% of aid budget and 20% of national budget to be allocated to the provision of basic needs for all.[58] Adopting the 20/20 pact would require states to adjust their existing development priorities. In doing so, the states can achieve the minimum level of their obligation (Felice 2001: 234).[59] Chapman however feels that by using the language of development rather than right this summit further marginalised the ICESCR (1996: 27).

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rights, by Danilo Turk, UN. Commission on human rights, sub Commission on prevention of discrimination & protection of minorities, 42ndsess. Provisional Agenda Item 7, UN. Doc. No E/CN.4/sub.2/1990/17(1991).

[56] See Para vii(3).

[57] See Blichitz'(2003: 1); see also Astlon & Quinn(1987:184).

[58] See UNDP, Hum. Development Report 1994 at 7.

[59] However he notes that poor countries will require international assistance.

2.6.3 Limitation to the Right to Health

Article 4 of the ICESCR permits a State to limit this right only in circumstances that are determined by law, in so far as such may be compatible with the nature of the socioeconomic rights and solely for the purpose of promoting the general welfare in a democratic society.

A literal interpretation of the article 4 with regard to the phrase '*determined by law*' may infer that refugees' right to access healthcare services can be limited by any limitations outlined in the South Africa laws. However this is not the case as such limitation need be: provided for by national law of general application which should be consistent with the ICSECR and should be in force at the time the limitation is applied (Limburg Para. 48); should not be 'arbitrary or unreasonable or discriminatory' (Ibid Para. 49); clear and accessible to all (Ibid Para. 50); and there should be adequate safeguards and remedies in the eventuality of illegal or abusive imposition of such limitations (Para. 51).In addition such limitation should apply for the well being of all (Ibid Para. 52), in a manner that does not impair the democratic function of the society (Ibid Para. 53 - 54) and jeopardise the essence of the right to health (Ibid Para. 56). This is in line with the interpretation given on this provision by the Limburg principles that: this article was not meant to introduce limitations on rights affecting the subsistence or survival of the individual or his integrity (Ibid Para. 47).

Chapter 3 – Africa, Human Rights & Refugees

The legal regime governing refugee laws in Africa consists of three main legal documents; the 1951 Convention and its 1967 Protocol; the 1969 Convention and the 1981 African Charter on Human and Peoples' Right.[60]

3.1 The 1969 Convention and the Right to Access Healthcare Services

This Convention is the regional international treaty that specifically protects refugees rights in Africa. The Convention neither contains a catalogue of rights as provided by the 1951 Convention nor a provision akin to article 5. There is no mention of rights beyond non-refoulement,[61] voluntary repatriation and its emphasis on non-discrimination.[62]

The absence of rights language in this Convention can only be understood by reflecting on the circumstance under which the Convention was made. In fact, Milner (2004:3) observes that for an effective understanding of the African refugee regime, there is need to consider the historical aspect of refugee movement in Africa and the relationship between the contemporary African system and international system.

The 1967 Convention was a result of dissatisfaction of African states of the international regime. The 1951 Convention did not reflect on the refugees' realities in

[60] Here in referred to as 'the Banjul charter'.
[61] The word *non-refoulment* derives from the French word '*refouler',* which means to drive back or repel*. The* principle of *non-refoulment* prescribes broadly that no refugee should be returned in any manner whatsoever to any country where he or she would be at risk of persecution.
[62] AALCO considers this to be one of its short comings. See Asian–African Legal Consultative Organization (2009).

Africa (Loescher 2001: 124). [63] The development of the 1969 Convention regime was stimulated more by concerns of domestic politics, national security and international recognition more than humanitarianism (Milner: 2004, 3). It was a regime preceded by a regime of maximum colonisation and intensified struggles for independence by African nations (AALCO 2001: 5).

Refugees in the 1960s and 1970s were fleeing from armed struggles against colonialism, racial domination and apartheid. This explains the definition of the term 'refugee' under the Convention.[64] It is from this historical background that the 1969 Convention was developed so as to capture the realities on the ground.

However before the Convention came into force, the 1967 Protocol was enacted and hence remedied some of the situations envisaged by the African community. As a result, the Convention became a regional initiative complementary to the 1951 Convention and its Protocol.[65] Essentially the 1969 Convention under its preamble calls states to accede to the 1951 Convention and in the meanwhile apply their own provisions to refugees in Africa.[66]

3.2 Establishing Links between the 1969 Convention, African Charter on Human and Peoples' Rights (ACHPR) and the 1951 Convention.

The preamble of the 1969 Convention recognises that the 1951 Convention and its Protocol constitute the basic and universal instrument relating to the status of

[63] See articles 2(3), article 5 and article 4 respectively. See also the preamble of the 1969 convention and article 1 for the definition of the term 'refugee'.
[64] See Crisp (2000); and Rutinwa (1997).
[65] See resolution CM/Res. 88(VII), 1966.
[66] See Preamble Para. 10.

refugees.[67] It recognises the principles contained in the Charter of the United Nations and the UNDHR with regard to enjoyment of rights and freedoms by all without discrimination.[68]

In 1981 the ACPHR came into force. The ACHPR unequivocally created states obligations as regard to rights and freedoms. These rights included the right to health for all. By using the phrase '*for all*' it can be persuasively concluded that this right included refugees. ACHPR is thus an additional source of refugees' protection in Africa.[69] The ACHPR Commission has interpreted the ACHPR broadly to promote and protect the rights of refugees, and has emphasised that African states who are not parties to the Convention but are parties to the Charter, are obliged to respect refugee rights (Ddamulira 2009: 181-182).[70] Moreover, under resolution 149, states are requested to '*implement AU spirit as liberal as possible*'.[71]

It can therefore be deduced from the above discussion that despite the regional treaty being quiet on refugees' rights, refugees can still claim their right to access healthcare services under this system.

[67] See Preamble para 10.
[68] See Preamble of the 1969 Convention Para. 6
[69] See also the AU supplementary forms of protection for vulnerable groups: The African Charter on the welfare of the Child entered into force in 1999. This in addition to providing the right to health requires states to ensure appropriate protection and assistance to the child asylum seekers or refugees; See also the Protocol to the ACHPR on the Rights of women in Africa.
[70] See *African Institute for Human Rights and Development(on behalf of Sierra Leonean Refugees in Guinea) v Guinea*(2204) AHRLR 57(ACHPR 2004); *Organisation Mondiale Contre la Torture & others v Rwanda*(2000) AHRLR 282(ACHPR 1996); *Mouvement des Refugies Mauritaniens au Sénégal v Sénégal*(2000) AHRLR 287(ACHPR 1997)
[71] Res. CM/Res 149(IX) 1968 Para. 6

3.3 African Regional Treaties and Refugees Rights to Access Healthcare Services.

Article 16(1) of the African Charter on Human and Peoples' Rights specifically provides for the right to health care. States are expected to take necessary measures to protect people's health and ensure that they receive medical attention when sick (ACPHR art 6 (2)). The measures to be taken under this article that are relevant to this study include: elimination of epidemics, availing health services to the people; promulgation of suitable health services: providing meaningful access to regulatory and decision making bodies that would empower people to demand against violation and providing essential drugs and preventive care.[72]

However this right under the ACPHR is not extensively drafted as it is in the ICSECR. The ACHPR lacks a provision that caters for emergency medical treatment (Umozurike 1983: 48). It also does not set the parameters for the realisation of socioeconomic rights unlike its counterpart the ICESCR. This has resulted in intensive debates on whether or not these rights are to be realised immediately.[73]

Nonetheless, Mbazira (2006: 342) is of the opinion that, this is not a hitch as many African states are parties to International Conventions. He (ibid) further remarks that the national Courts and the ACPHR Commission are on many occasions compelled to rely on the international treaties and jurisprudence.

The ACHPR commission has played a major role in interpretation and enforcement of the right to health. In addition it has assisted in establishing the parameters of

72 See Umozurike **(**1983**:** 902-912).
[73] See Odinkalu (2002:196).

exercising the right to access health care and the right to health in general. Consequently, Courts have given wide definition to this right. In the *Zaire case*[74], the Commission held that the failure of the government to provide services such as water and electricity and a shortage of medicines also amounted to violation of the right to health. Unfortunately in this case the Commission did not give the right to health its fullest interpretation (Ankumah 1999: 2).[75] However in the *SERAC*[76] *case*, the Commission observed that, rights create at the very least three duties: to protect, promote and fulfil. These duties universally apply to all rights and the need for enjoyment of some of the rights requires actions from states in the form of more than one of the duties above. Further in *Purohit case*[77] the Commission reiterated the principle of indivisibility and dependency of rights[78] and observed that this requires that the right to health facilities and access to goods and services are to be guaranteed without discrimination of any kind while taking full advantage of the states available resources.[79]

A case in point that would be relevant to refugees in detention is the *Nigerian case*.[80] Here the Commission observed that the responsibility of the government to provide health care is heightened in cases where individuals are in custody. And that to deny a detainee access to doctors while his/her health is deteriorating would

[74] *Free Legal Assistance Group v Zaire* (2000) AHRLR 74 (ACPHR 1995). This marked the commission's shift to the progressive phase, see Mbazira op cit 348 for a detailed discussion on the various phases that the commission has under gone; Also see *Malawi African Association v Mauritania* (2000) AHRLR 149(ACHPR 2000).
[75] This have been said to be the redundancy phase for the Commission.
[76] *Social and economic rights action centre (SERAC) & another v. Nigeria* (2001) AHRLR 60 (ACHPR2001) Para 44.
[77] *Purohit & another v. The Gambia* (Purohit case)(2003)AHRLR 96(ACPHR 2003).
[78] The commission held that the enjoyment of the right to health under article 16 is vital to all aspects of a person's life and well-being and is crucial to the realisation of all other rights.
[79] Ibid Para 80.
[80] Media *Rights Agenda and Constitutional Projects v Nigeria*, twelfth Annual Report of the Commission-1998/1999. Accessed at http://www1.umn.edu/humanrts/africa/comcases/105-93_128-94_130-94_152-96.html

amount to violation of Article 16.[81] Despite the Commission's major role in enforcement of refugee rights, Ddamulira however points out the fact that the Commission decisions have been based on the ACHPR and not the 1969 Convention. He therefore recommends that in matters relating to refugee rights the Commission should always invoke the provision of 1969 Convention and ACHPR and only make reference to other refugee related instrument where necessary (2009).

Article 1 of the charter obliges the states to '*undertake steps to adopt legislative or other measures that give effect*" to the rights as contained in the ACPHR. The failure to adopt legislative measures by any member state as required under article 1, does not permit it to rely on its national laws as a validation for its non-compliance.[82] This would be in line with international standards as reinstated in the *German's case*[83] where the Courts held as follows:

> *---from the stand point of international law and of the Court which is its organ, municipal laws are merely facts which express the will and constitute the activities of states in the same manner as do legal decision or administrative measures.*[84]

Refugees are therefore entitled to the right to access healthcare services under the regional refugee regime. The mere absence of a right to health in the 1969 Convention does not automatically exempt refugees from realisation of their rights;

[81] On sad a note however, this recommendations among others were not executed by the relevant countries. Mbazira is of the opinion that the introduction of the African Court marks a new phase, a phase of significant strides with more mandate than the commission. See Article7, 29(3), & 60 of the African Court protocol. For a detailed discussion see Mbazira (2006:354-357); Evans & Murray (2002).
[82] See *Legal Resource Foundation v Zambia taken* at the 29th sess. Held in Tripoli (Libya) from 23 April to 7th may 2001, 14th Annual Report of the Commission-2000/2001, AOU Doc AHG/Dec.29 (XXXVII).
[83] In certain Germany interest in Polish upper Silesia, merits, judgement No. 7, 1926 PCIJ, series A, No. 7.
[84] Ibid @ p.19 of the judgement. See also article 27 of the Vienna Convention on the Law of Treaties 1969.

neither does the absence of parameters and the limitations clause in the ACPHR make the right to health absolute. Refugees' right to access healthcare services are subject to the limitations and parameters set under the International regime as observed by the decisions discussed above.[85]

[85] See Ouguergouz (2003: 98-100).

Chapter 4 – South Africa, Compliance, and International Human Rights Standards

4.1 Links between International, Regional and National Laws Regarding Refugees' Rights.

The era prior to the enactment of the current Refugee Act, was characterised by a legal regime that was unconstitutional and which failed to protect or guarantee the general refugee rights (Klaaren 1996, 1998; Crush 1998; Klaaren and Springman 2000). The regime was governed by the Alien Control Act.[86] This was an omnibus of legislation which aimed at restricting numbers of migrants (Peberdy and Crush 1998).

In 1995 South Africa became a party to the 1951 Convention, the 1967 Protocol and the 1969 Convention. As a result, these international agreements became binding on the state. South Africa has a dual approach to international treaties.[87] In line with this, s 231 of the South African Constitution outlines the process of domesticating international treaties in South Africa: the treaties have to be approved by both the National Assembly and the Councils of Provinces. [88]However, Courts are required to consider international law when interpreting the Bill of Rights under s 39(1).

In line with s.231, the Refugees Act (1998) [89] was promulgated in order to give effect to the relevant international legal instruments, principles and standards relating

[86] It has since been repealed and replaced by the Immigration Act 13 of 2002.
[87] *See* Olivier (2003: 293-310).
[88] Except for self executing and customary international laws. See s 231 and s232 of the constitution.
[89] The Act was assented to on 20 November 1998 and was put into effect as from 1 April 2000 (Proclamation No 22 of 2000, *Government Gazette* No 21075 of 6 April 2000).

to refugees and to provide for the rights and obligations flowing from refugees' status amongst other things.[90]

The application and interpretation of this Act should be done with due regard to the 1951 Convention and the 1967 Protocol, the 1969 Convention, the UNDHR; and other treaties as provided under s 6(1).

4.2 The Legislative Framework on Refugees' Right to Health Care Access in South Africa.

S 27(1) (a) of the Refugees Act (1998) is important for this study as it provides that refugees are entitled to the rights enshrined under the Bill of Rights in the Constitution. S 27(1) (g) explicitly provides that refugees are entitled to the same basic healthcare services as citizens. The above provisions with regard to this right are in line with the Constitutional guarantees to access healthcare services and emergency treatment as provided under s27 (1) (a) and s27 (3) respectively. Although s27 (3) of the Constitution is absolute, s 27(1) (a) is subject to progressive realisation within available resources as stipulated under s 27(2)

One of the aims of the National Health Act (1996) (NHA) in the South African context is to protect, respect, promote and fulfil the rights of vulnerable groups.[91] The use of the terms "*such as*" infers that the list given under s2(c) (IV) of vulnerable groups is not exhaustive and that it is just an illustration, hence refugees can be included. In addition the provision of eligibility under s 4(3) (b) of the National Health Act also obliges the state to provide for all people with free primary healthcare services

[90] See the Preamble and the long title of the refugee Act.
[91] See the preamble of the National Health Act and the objects of the Act under S2.

except for those excluded in the section.[92] By using the phrase '*all people*' in the subsection, it can be inferred that refugees were also covered by the subsection. Therefore refugees as '*people*' are entitled to all the rights protected under the NHA. S 5 of the NHA is also important to the issue at hand as it requires that health professions and providers not deny any person emergency treatment. By the use of the terms "*any person*", it can also be arguably inferred that refugees fall within the definition of these terms.

In addition, the Patients' Rights Charter, proclaimed by the Department of Health (DOH), provides that there must be provisions for the special needs of vulnerable groups. These vulnerable groups have been understood to include *inter alia* refugees (SAHRC 2009).

From the above discussed provisions of the laws, it is evident that refugees' right to access healthcare services is guaranteed under the South African law. This therefore lays the foundation for refugees claim for the fulfilments of that right within the parameters set by the Courts as discussed in the next section.

4.3 South African Court Interpretations on Socio-economic Rights

As mentioned earlier, rights relating to health e.g. access to healthcare fall under the gamut of socioeconomic rights. Socioeconomic rights are justiciable in South Africa.[93] The Courts have been proactive in establishing the parameters of the right

[92] See s 4(3) (b) of National Health Act (1996).
[93] Ex Parte Chairperson Of The Constitutional Assembly ;In Re Certification of the Constitution of RSA, 1996(4) SA 744(Cc) (1996 (10) Bclr 1253) In Para[78], case followed by TAC.

to access healthcare services in South Africa. They have adopted the purposive approach of interpretation as adopted in *Makwanayane*.[94]

Although the important South African Court decisions on health (such as *TAC* and *Soobramoney*) did not specifically deal with refugees, this does not mean that the states have totally different obligations when refugees are involved.

A case relevant to states obligations to refugees is *Kiliko's,*[95] where the Court held the that under international law, the state is obliged to respect the basic human rights of any foreigner who has entered its territory and any such person is entitled to all the fundamental rights entrenched in the Bill of Rights, other than those expressly restricted to South African citizens. Consequently these Court decisions provide guidelines on refugees' entitlements.

Therefore to understand the nature and scope of refugees' entitlement the study proceeds to look at various decisions on the enforcement of socioeconomic rights.

4.3.1 Enforcement Of Socioeconomic Rights Under S27 (1)(A) And 27(2)

In *Soobramoney's*[96]*case* the Court held that state obligations imposed under the right to access healthcare services were dependent upon the resources available for such purposes. The Court further observed that, the rights under Article 27(1) of the

[94]*S v Makwanayane & anor* 1995 (3) SA 391(CC) (1995 (2) SACR 1995(4) BCLR 665). Meaning the rights should not be interpreted in isolation but in their context, which include the history and background to adoption of the Constitution, other provisions of the Constitution itself and particular, the provision of the Bill of Rights of which they are a part, see par 10 in Soobramoney *V Minister Of Health*, KZN 1998(1) Sa 765 Chaskalson J's decision.
[95] *Kiliko& Ors V Minister Of Home Affairs &Ors* {2007] 1all Sa 97(C).
[96] *Soobramoney V Minister Of Health* supra .

South African Constitution may be limited because of lack of resources. Accordingly the right to access healthcare services, just like other socioeconomic rights is subject to distributive justice.[97] With regard to this point the Court held that the state was under a duty to manage its limited resources in order to address all basic claims made upon it.[98]

It therefore follows that sub-sections 27(1) and 27 (2) are linked and should be read together (TAC 2000). Measures undertaken by the government should be gauged on whether or not they are aimed at progressive realisation of the right under s27 (1) (Bilchitz 2003: 6). In relation to this, Yacoob J. in the *Grootboom case* gave a clear scenario of the circumstance that mandates the state to progressively realise these rights. He observed that:

> *This case shows the desperation of hundreds of thousands of people living in deplorable conditions---- the Constitution obliges the state to act positively to ameliorate these conditions. The obligation is to provide access to housing, health care --- to those unable to support themselves and their dependants. --- Those in need have a corresponding right to demand this to be done.*
>
> *I am conscious that it is an extremely difficult task for the state to meet these obligations in the conditions that prevail in our country. This is recognised by the Constitution which expressly provides that the state is not obliged to go beyond available resource or to provide these rights immediately. I stress, however, despite all these qualifications, these rights and the Constitution obliges the state to give*

[97] The decision was also followed in *Minister Of Health & Ors V Treatment Action Campaign & Ors* (No 2) 2002 (5) SA 721, commonly known as TAC's case.
[98] In relation to this Chaskalson observed; '*There will be times when this requires it to adopt a holistic approach to the large needs of society rather than focus on the specific needs of particular individuals within the society*.' Ibid at Para 31.

effect to them. This is an obligation that Courts can, and in appropriate circumstances, must enforce.'- (par [93]-[94])

In realisation of the right to access healthcare services progressively, there is however a need to recognise that people have urgent needs which if not met would render the rights as enshrined in the Constitution meaningless. (Blichitz: 2003: 11).

4.3.2 Test of Reasonableness

The Court introduced in the *Grootboom* case as well as confirmed in the *Treatment Action Campaign* case *(TAC*), the notion of `*reasonableness*' as the standard of review for evaluating the State's compliance with its Constitutional obligations. In the *Grootboom* case [99] the Court observed that reasonable measures should take into consideration: the degree and extent of the denial of the right they endeavour to realise; those whose needs are most urgent and whose ability to enjoy all rights are most in peril; that a programme for the realisation of socio-economic right must be balanced and flexible and make appropriate provision for short, medium and long term needs and crises; and such a programme should not exclude a significant segment of the population.[100]

In addition, in reference to *Khosa's* case Blitchitz (2005:13) adds that a reasonable programme must allocate task and responsibility to different spheres of government;

[99] *Government of South Africa & ORS v Grootboom & ORS* .2001(1) SA 46 CC (2000(11) BCLR 11690.
[100] See *Government of South Africa & ORS v Grootboom & ORS* supra at par 43. The decision also followed in TAC case.

ensure appropriate human and financial resources are available; be capable of facilitating the realisation of the right involved; and not discriminate unlawfully.

According to Hoexter (2001: 301) decisions that are reasonable are positioned between correctness and capriciousness; supported by reasons and verifications that rationally connect to a purpose; are objectively capable of furthering that purpose; and mimic proportionality between ends and means and benefits and detriments.

Bilchitz (2005:11) observes that this notion, whilst leaving a margin of appreciation to the body making the original decision to decide on measures that need to be taken on socioeconomic rights, is designed to facilitate significant judicial review by the other arms of government.

However, Klaaren (2003: 445) is of the opinion that the adoption of the reasonable test by the Courts does not shut down the direct enforcement of these rights. This is because the Courts decision in the *Fose* case can be used as a premise to develop innovative remedies where necessary. In the *Fose* case[101] the Constitutional Court called upon Courts to '*forge new tools' and 'shape innovative remedies*'.

4.3.3 Minimum Core Obligation

The South African Constitutional Court has rejected the minimum core approach in the enforcement of the socioeconomic rights. In the *TAC* case [102] the Court while

[101] *Foser v .Minister of Safety & Security* 1997 (3) SA 768(cc).
[102] TACs Supra

referring to the *Grootboom* case observed that although Yacoob J. in *Grootboom* indicated that evidence in a particular case may show that there is a minimum core of particular services that should be taken into account in determining whether measures adopted by the state are reasonable, socioeconomic rights should not be construed as entitling everyone to demand that a minimum core should be provided to them. Further the Court held that minimum core should be treated as possibly being relevant to reasonableness under s27 (2) and not as a self standing right conferred under s 27(1). However, the Court observed that the state has to act reasonably to provide access to socioeconomic rights in s 27on a progressive basis.

Despite the Courts' rejection of the minimum core approach and the fact that the rights enshrined in the Constitution may not be realised in the near future, this does not imply that socioeconomic rights should not have been included in the Constitution. This is because scarcity does not affect the moral value of the right but the capacity to realise them (Chamba 2009:21). In addition Courts have suggested that this concept may be of assistance in considering the reasonableness of states actions with regard to socioeconomic rights (Liebenberg 2002:159)

4.3.4 Emergency Treatment

Section 27(3) of the Constitution and s 5 of National Health Act arguably provides that the right to emergency treatment is absolute. It therefore follows that refugees cannot be denied access to such treatment in private and public facilities. Chaskalson P. In the *Soobramoney case* observed that this right is couched in negative terms and that the purpose of this right seems to be to ensure that

treatment is given in emergency, and is not frustrated by reason of bureaucratic requirement or other formalities(Para 20). Although Courts have rejected the concept of minimum core, the possible understanding of the s 27 (3) is that, the subsection flows from the minimum core obligations as set out under international laws.

In an attempt to define what amounts to emergency treatment, the Courts observed that the *Paschim's* case[103] presented circumstance that would fall within s 27(3) in that the occurrence was sudden; the patient had no opportunity of making arrangements in advance for the treatment that was required; and there was urgency in securing the treatment in order to stabilise his condition (Para 18G).

Therefore, in line with the *Soobramoney* case a refugee would only be entitled to emergency care under the following circumstances: where there is a sudden or unexpected event or catastrophe;[104] the event is of a passing nature and not continuous; [105]the event leads to him/her requiring medical attention or treatment;[106] and that the treatment required is necessary and available.[107]

Any other treatment would therefore fall under s 27(1), and would hence be subject to the provision of s 27 (2). The reasons for prioritising emergency treatment over other treatments are that it would make it more difficult for a state to fulfil its primary obligations under subsections 27 (1) and (2) (especially if the purpose for such

[103] *Paschim Banga Khet Mazdoor Samity & Ors V State Of Westbengal & Anor* (1996) AIR SC2426.
[104] See Soobramoney V Minister Of Health supra at Para 18-20.
[105] Ibid See Para 21, 38.
[106] Ibid Para 18b.
[107] Ibid Para 20. See also the comment on Paschim Banga Khet Mazdoor Samity & Ors V State Of West Bengal & Another(1996) AIR SC2426 by the Courts at Para 18G.

treatment is for prolonging life) and it would reduce the resources available for other purposes such as preventive health care.[108]

4.3.5 Implementation of the State's Obligations by the DOH

There is tangible evidence that the DOH has made an attempt to comply with obligations created on the government with regard to the refugees right to access healthcare services. It has formulated and dispatched various policies and directives to clarify the rights of refugees to various health care facilities.

The HIV & AIDS and Strategic Plan for South Africa (2007), a multisectoral response to South Africa's AIDS epidemic, which calls for treatment, care and support for 80% of HIV positive people by 2011, expressly includes refugees. Also In February 2007 the Project Manager: Comprehensive HIV /AIDS Care, Management and Treatment (CCMT) of the NDOH addressed a memo to Provincial Managers and CCMT Project Managers to the effect that patients should not be denied ART by the mere fact that they did not posses identity documents. This was followed by a directive from the NDOH on September the same year reinstating the provision of s 27(g) of the Refugee Act. It instructed that refugees or asylum seekers with or without permits should have access to public health services and that the citizen's means test should apply to them. In 2008 the Gauteng DOH elucidated in a memo that no patient should be denied access to healthcare services including ART irrespective of whether or not they possessed Identity documents.

[108] See Chaskalson P. Judgement in *Soobramoney V Minister Of Health* supra on the emergency treatment for the purpose of prolonging life at Para 11-13.

In addition the **'**Batho Pele' Policy Document is a very important document, with regard to refugees' access to healthcare services. The policy lays down eight national service delivery principles, which act as guidelines for transforming public service delivery (1997).[109] Therefore since refugees under s 27 have the same rights as citizens and the fact that the rights, save for political rights are an entitlement of all who live in South Africa, public health care providers are expected to deliver their services to refugees with due regard to these principles.[110] This is supported by the background statement of the 'Batho Pele' policy which clearly states that: "*Public services are not a privilege in a civilized and democratic society: they are a legitimate expectation.*"

From the above discussion, it is clear that South Africa has taken adequate legislative measures to protect and promote the refugees right to access healthcare services as required under article 2(1) of the ICESCR and the South African Constitution. However legislative measures are just one of the measures expected to be taken by states under the ICSER and the Constitution. Bearing in mind that all Constitutional obligations must be performed diligently and without delay,[111] the next chapter reflects on how the state has implemented the obligations shouldered upon them by the above discussed international, regional and national laws.

[109] These principles include: Regular consultations with its users; Setting service standards; Increasing access to services; Ensuring higher levels of Courtesy; Providing more and better information about services; Increase openness and transparency; Remedying mistakes and failures and; Getting the best possible value for money.
[110] See Centre for the Study of Violence and Reconciliation and UNHCR (2001). *This study observes that* the concept of citizen as customers as explained in the Batho Pele document does equally applies to refugees because South Africa belongs to all who live in it.
[111] See s. S 237 of the constitution of RSA.

Chapter 5 – Problems in the Provision of Access to Healthcare Services to Refugees

Although the DOH as a government department is expected to progressively realise refugees' right to access healthcare services, the existing empirical evidence indicates that access to basic health care is insufficient. While commenting on urban refugee policies, the UNHCR regional representative, Ebirma Camara pointed out the fact that, refugees policies have failed to address some of the pertinent challenges in the realisation of their rights such as *"access to national public services---"(*IRIN news, 2006: 1). In addition the Human Rights Watch (HRW) have pointed out that legal guarantees enshrined in the Constitution have not yet been fully put into practice by those responsible for the protection and promotion (2005). The anecdotal and empirical evidence available depicts the fact that discrepancies still exist in delivery of healthcare services to refugees in South Africa.

In research carried out by the Forced Migration Studies (Wits) (FMS), the finding was that 72.5% of the migrants' participants reported no difficulties in accessing public health care. However the research concluded that, although the percentage of those who reported to have had difficulties in accessing public facilities was lower, the percentage (27.55%) of those who reported having difficulties in accessing healthcare services was relatively high (FMS 2008: 17).[112] In a national study that specifically focused on refugees, it was found that 17% of participants had been denied emergency medical care (Belvedere 2003).

[112] The report also noted that one has to consider the numbers of citizens who claim to have difficulties in accessing such services.

The key facts that have attributed to refugees non-realisation of this right are:

- Discrimination
- Lack of access to information
- Barriers to emergency care for rape survivors
- Legal fees

5.1 Discrimination

Article 2(2) of the International Covenant on Economic Social and Cultural Rights (ICESCR) introduces the principle of non-discrimination and equality.[113] These two principles are closely related and non-discrimination is said to be a positive expression of equality (Mckean 1983). The two constitute a basic and general principle relating to the protection of human rights**.**[114]The International Convention on Elimination of all Forms of Racial Discrimination (ICERD) as the main international instrument that deals specifically with aspects of discrimination aims at guaranteeing equality in enjoyment of rights (Meron 1985: 287).[115]

Under article 5, the ICERD obliges states to take positive steps to prohibit and eliminate discrimination and promote equality in enjoyment of rights.[116] In line with this provision, the Committee on Convention on Elimination of all Forms of Racial Discrimination(CERD) calls states to eliminate discrimination with due regard to the

[113] See the ICESRC's preamble which reiterates the principles of equality, inalienability and inherent nature rights.
[114] See Human Rights Commission Gen.Com 18-Non- discrimination adopted at its 948th mtg. Thirty-seventh sess. , held on 9th Nov. 1989, para 1.
[115] See ICERD preamble which refers to enjoyment of human rights without discrimination. See also Article 2(1) of International Covenant on Civil and Political Rights.
[116] See also Article 2(1) on state duty to take policy measure eliminate any law that creates discrimination.

principles set in the UNDHR. These principles should be understood in their entirety.[117]

Article 7 of the UNDHR provides that all persons are entitled to equal protection of the law without discrimination. Important to the study also is article 22 of the UNDHR, which stipulates that the realization of socio-economic rights is "*indispensable*" for human dignity.[118] By bringing the concept of dignity, it can be argued that the UNDHR reflects the fact that realisation of socioeconomic rights are vital to human existence. Every life has ethical significance and any disparities that may result out of social, economic or political factors are unacceptable.[119] Hence, it follows that the limitations provided under the wording of article 29 of the UNDHR that, '*rights are relative rather than absolute*', can only applied be within the circumstances envisaged under article 29(2) & (3) of the UNDHR. Even then there should be concrete evidence to support such a limitation.[120]

Hendrika's case[121] was a clear reflection of the fact that non discretion and rights are discernible. And although no violations were found, testing the denial of a sickness benefit against article 26 of the International Covenant on Civil and Political Rights (ICCPR) by the Human Rights Commission illustrated the willingness to read social rights into the non discrimination clause (Toebes 1999: 674).

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[117] See Article 4 of ICERD and CERD,9th session(189th mtg) at 65, U.N Doc. CERD/C/SR. UNDHR 189 (1974)

[118] Article 1 UNDHR states: "*All human being are born free and equal in dignity and rights.*"

[119] See the Alma-Alta Declaration on Primary Health Care (1978).

[120] See article 29(2) & (3) of the UNDHR, the former provides limitation of rights due to exercise of rights and freedoms of others and for societal good and the latter stipulates that rights should not be exercised contrary to the purpose and principles of United Nations. Further see article 1(3) of UN charter, which states one of its purpose as to promote and encourage respect for human rights and fundamental freedoms for all without distinction as to race.

[121] *Hendrika & Others v. The Netherlands* Communication 218/1986, UN GAOR. HRC 44th session, supp. No 40,323, UN Doc A/44/40(29 March 1989), although the case considered whether the denial of a disability benefit violated art 26 of the ICCPR.

A literal interpretation of article 1(2) of the ICERD and article 2(3) of the ICSECR[122] may arguably point to the fact that the states have discretion in fulfilling the refugees' rights to healthcare services. However this is not the case. The reason for this are:

- First by employing art 31(1) of the Vienna Law of Treaties which provides that '*recourse may be made to travaux preparatoires to explicate the drafter intention*'. Several articles have implied that non-citizens are not completely unprotected as it was the intention of the drafter to protect the 'non-nationals' (Mahalic & Mahalic 1987: 76). To support this finding one can further use the CERD recommendation that stipulates that a Convention which excludes non-citizen should be confined narrowly.[123]

- Secondly, Mahalic and Mahalic (1987:77) point out that because refugees and migrant workers usually belong to a single ethnic group, any form of discrimination against them risks being indistinguishable from racial discrimination despite article 1(2). Moreover the CERD has reminded states of their obligations towards non-citizens and obliges them to remove obstacles that prevent enjoyment by non-citizens of the right to health and to respect their right to adequate standards of health: by *inter alia* refraining from denying or limiting their access to preventive, curative and palliative health services.[124]

[122] See article 1(2), a limitation clause that restricts the extent to which certain provisions of the Convention apply to non citizens. See Mahalic & Mahalic.(1987:75-76).
[123] See CERD, 16th sess. (345th mtg.) at 60 Para 43 U.N Doc. CERD/C/SR.345 (19 7) also see CERD, 8th sess. (148th mtg) at 37 U.N. Doc. CERD/C/SR 148(1973).
[124] See Gen. Recommendation 30, Para 29 & 36.

Stressing the provision of art. 2(2), the Committee on Economic Social and Cultural Rights has observed that the definition of the normative content of the right to health care involves equal access, based on principle of non-discrimination to health care facilities and that ensuring non-discrimination on the right to access health facilities, goods and services is one of the minimum core obligations placed on state parties. [125] They further observed that the full realisation of the ICESCR rights will aid in elimination of discrimination and xenophobia.[126]

The Constitution also guarantees refugees rights to equality and freedom from discrimination.[127] A case in point is that of *Khosa v Minister of Social Development*.[128]Here the applicants had challenged the Constitutionality of the then Social Assistance Act[129] that excluded permanent residents from social assistance grants. The Court held that since other rights do not contain modifications such as those contained on political rights and the right to access land which expressly limit these rights to citizens, s 27 applies to '*everyone*'.[130] In addition the Constitution under s.195 (1c) provides that public administration should adhere to the principles of impartiality, fairness, equitability and without bias among others. Important also is s.195 (1e) which explicitly provides that people's needs should be responded to.

Therefore the presence of any discriminatory incidents against refugees with regard to access healthcare services would be a reflection on the states failure to meet its obligation under International treaties and the Constitution.

[125] See General comment 14 Para 43.
[126] See Preparatory Committee, World Conference against Racism, Racial Discrimination, Xenophobia & Related Intolerance (2000).
[127] See s 9 of the 1996 Constitution.
[128] *Khosa v Minister of Social Development* 2004(6) BCLR 569(cc).
[129] Act 59 of 1992.
[130] See *khosa*'s case supra judgement of Makgoro J at para 47.

5.1.1 Xenophobia

Various studies and publications have reported incidents where health care workers have displayed discriminatory and xenophobic attitudes towards refugees. For example Palitza (2008) has documented an account given by a one Eric[131] who in confirming the issue claimed that:

> *We are treated with contempt, are made to stand in the back of the queue or ignored. And in the end, many of us are sent home without any medication (IPS: 2008).*

Xenophobic and discriminatory attitudes have also been traced from the front line staff and nursing staff (LHR: 2008). In a Médecins Sans Frontières (MHF) report to the Gauteng DOH, the report includes accounts given by various people including that from a medical student who gave an account of some unethical and abusive behaviour that he witnessed in Hillbrow Community Health Clinic by members of the nursing staff. He claimed that the nursing staff would harass and abuse refugee patients (2008: 64). In addition, the UNHCR has also given an account of various incidents where health professionals have displayed xenophobic attitudes towards refugees (IPS: 2008).

It is sad to read about refugees giving accounts of xenophobic attitudes from health care workers. This is because health care workers work in an environment that demands empathy. For example Sefu aired his sentiments as follows: '*xenophobia is still here. Only now it lives at the hospital*.' (Quoted in HRW 2009: 54). Patterns of

[131] A Burundian refugee living in South Africa. For a detailed account on xenophobic attitude by health professions see *Pritchard* (2000: 71).

discrimination are also evident in the initial stages of accessing health care such as calling for an ambulance (HRW ibid).

There are several factors that fuel xenophobic attitudes. These factors include:

1. The misconception that refugees are health immigrant;
2. Citizens dissatisfaction with the government's failure to provide for services (COMRSA 2008:27)[132];and
3. A long-standing government acceptance of extortion, violence, and abuse levelled against non-nationals (COMRSA: 2008; 27).[133]

The white paper on International Migration is a good example on one of the ways that the government has contributed to this[134]. Among other things the paper introduced the concept of "*community*". By introducing this concept the paper has been criticised as creating the feeling of "*distinctiveness*" and "*hence refugees are clustered as the others*" (Handmaker 2001:105 emphasis mine).

In addition, the paper also empowers citizens to cooperate with internal policing actions so as to ensure that illegal immigrants "- *are not attracted to South Africa*." (RSA 1999: 4. 4.1). Handmaker (2001: 105) remarks that although the state had not anticipated nor intended to create tension, this approach has a possibility of creating divisions within the communities and of intensifying the levels of xenophobia.

[132] COMRSA stands for Consortium for Refugees and Migrants in South Africa.

[133] See also Bonaventure Rutinwa, (1999:1-2).

[134] The paper was not meant to deal with refugees matters. Nevertheless there were indication that it would affect them .See Handmaker (1999).

Xenophobia creates an environment that promotes risks to refugees' health. It also creates refugees' barriers to obtaining basic health care (HRW: 2009, 2): By creating fear among the refugees, they may shun seeking health care, more so where they lack proper documentation. The xenophobic attitudes by health professions are unconstitutional and contravene the above discussed provisions of the law. They also contravene s 9(3) and (4) of the Constitution. Such acts fall within unfair circumstances outlined under s 9(5) of the Constitution and may in certain cases contravene the provision of s 5 of the NHA which obliges health workers not to refuse any person emergency medical treatment. Furthermore, such behaviours contravene s 6 of the Promotion of Equity and Prevention of Unfair Discrimination Act (2000) and falls within the illustrative list of unfair practices under the schedule number 3 of s 29.[135]

Apart from academic qualifications, it is crucial for health care workers to possess personal qualities such as empathy and compassion, and some basic knowledge of the problems that refugees face in general. The latter may aid in changing the health care workers attitudes towards refugees and make them more receptive.

5.1.2 Scarce Resources

Scarcity of resources is one of the limiting factors towards attainment of Constitutional guarantees (Madala, P 779 par h).[136]With high prevalence in

[135] The Promotion of Equity and Prevention of Unfair Discrimination Act. No. 4 of 2000. An Act was enacted to give effect to s 9 of the Constitution.
[136] In *Soobramoney's case* supra. For a detailed discussion on the issue see Third Session of the African Union Conference of Ministers of Health Johannesburg, South Africa (2007:5-14).

HIV/AIDS and other related diseases like TB, the South African health system is overstretched and strained.[137] Justice Madala summarised this dilemma as follows:

> *[T]he appeal before us brings into sharp focus the dichotomy in which a changing society finds itself and in particular the problems attendant upon trying to distribute scarce resources on the one hand, and satisfying the designs of the Constitution with regard to the provision of health services on the other. It puts us in a very painful situation in which medical practitioners must find themselves daily when the question arises: "Should a doctor ever allow a patient to die when the patient has a treatable condition?*[138]

The fact that health systems are overstretched neither justifies discriminating against refugees nor remedies the problem on scarcity. Reasons which support this are:

1) Empirical evidence exists that contradicts the popular belief among South Africans that most foreigners are health migrants, and hence a burden to the already overstretched and resource constrained public health system (FMS May 2008: 17);[139] and,

2) A clear consideration of international and national obligations places a duty on the state to equitably distribute the available resources as discussed above in the introduction to this subsection.[140] Scarcity of resources exists only as a limitation on the state's ability to fulfil the Constitutional guarantees, under s 27. It does not in

[137] Out of 38. 6 million living with HIV/ AIDS worldwide in 2006, 24. 5 million were said to be in sub-Sahara Africa see UNAIDS (2006).
[138] *Soobramoney's case* supra at p.778 Para 4o.
[139] Reason that supported this conclusion were that; less than half of the participants in the study were in need of health care since arriving in South Africa; majority of foreigners in need of ART discovered their status after a period of stay in South Africa; and that they only tested after getting sick .
[140] See art 7 of UNDHR and s9 of the South Africa Constitution; see *also Minister of Finance v Van Heerden* 2004(6) SA 121(cc) par. 23.

any way limit the content of these rights.[141] In addition, since the proclamation of Teheran of 1968, the International Community has time and again restated the concept of equality of rights (Dankwa et al: 1998, 713).[142]

The state cannot therefore argue that their primary responsibility is to its citizens' needs with regard to healthcare services over refugees' needs. It cannot also assert that the right was non-existent before the enactment of the Refugee Act and hence it had no budgetary allocation for refugees.

In the *Khosa* case,[143] the Court held that it would not simply accept a statement by the state that it could not afford to extend its benefits to a group for which it had not previously catered for. The Court observed that a criterion according to which exclusion occurs must be consistent with the purpose of the Bill of Rights and must not amount to unlawful discrimination or create a serious impact on dignity.

It therefore follows that the state has an obligation to equally distribute health care resource to all who live in South Africa, including refugees. Healthcare services should consequently be availed on a first come first served basis except for circumstance envisaged in the *Soobramoney* case and/or where the state has taken temporary measures to achieve *defacto* equality to remedy the pre-existing inequalities as envisaged in article 1(4) of the ICERD and s 9 (2) of the Constitution. After all, equity aids the vigilant and not the indolent. Nevertheless where healthcare is denied for a valid reason, such a denial should be accompanied by an explanation

[141] See *Grootboom* supra Para 94.
[142] See article 1 of UNDH, article 26 ICCPR, and CEDAW.
[143] *Khosa v Minister of Social Development* at Para 45.

to the refugee patient on the reasons for the denial. Where preferential measures are taken, they should be discontinued once equality is achieved.[144]

5.1.3 Documentation

Although having adequate and well recognised documents can facilitate claims to social services including healthcare services, refugees face challenges in obtaining suitable Identification (Landau 2006: 316 emphasis mine).[145] This might have been one of the reasons for the DOH directive instructing public health establishments to offer refugees services regardless of their status. However notwithstanding the DOH directive, there have been reported incidents where health staff have denied refugees healthcare services for not having the proper documents.

The TAC has documented incidents where Zimbabwean refugees have been denied ART treatment due to lack of proper documentation.[146] Other studies that have reported similar findings include COMRSA (Feb & June 2008), FMS (2008) and HRW (2009). For example a research report by COMRSA has documented an interview done on a nurse, who observed as follows:

Some are referred from (government sites), some by friends…they say they have got no IDS; they have IDS, but they are written, "Born in Zim," and they only accept those with South African citizen (ship).

[144] See Article 1(4) of ICERD see also article 2(2) ICESCR.
[145] See Landau (2006:318); she observes that the physical form of Asylum seeker documentation contribute to the delay and irregular practice faced by asylum seekers while trying to obtain proper documentation.
[146]See Equal Treatment by Treatment Action Campaign Publication accessed at http//wwww.tac.org.za/community/files/file/et25.pdf.

In addition the FMS has also reported that only refugees with valid status are able to access ART in the government sector, while the rest are referred to the NGO sector (2008). The requirement for documentation has made many refugees with or without legal status shun away from seeking health care. (IPS: 2008).

The failure by health workers to implement the above the DOH policies are a contravention of the law. This is because such directives are among "*other measures*" that the state is supposed to take for the realisation of this right. Moreover s 44(1) of the NHA stipulates that a user may attend any public health establishment for the purposes of receiving health services. The only circumstance that a public health establishment can refer a user to another establishment is where such a facility is incapable of providing the necessary treatment or care as provided under s 44(2) NHA. Even then the transfer should be done to another public establishment.

Therefore the acts of referring refugees to NGOs by health professions are in contravention of the above section. Further, the NHA under s 81 requires health officers to monitor and enforce compliance with the Act. The COMRSA attributes the lack of policy implementation to a deficit in coordinated government self-monitoring, either by the leading agency such as the DOH or by a dedicated cluster of department representative (COMRSA 2008).

5.2 Lack of Access to Information

Making available the relevant information that the refugees may need in order to seek healthcare services, is one of the significant strides that the state should take

towards converting their legal rights to an entitlement. In addition, the policies adopted by the DOH should be effectively communicated to the relevant authorities and monitored. This would improve attainment of the pre-existing rights and guard against violations.

5.2.1 Inadequate, Inaccurate and Misleading Information to Refugees

Despite the existing laws and directives, that form a basis for refugees to claim and enjoy their right to access health care, it is evident that refugees are oblivious of services available to them as a right, and the nature and scope of this right (HRW 2009:8). This has been attributed to the fact that the state, through the DOH has not conducted basic outreach and educational initiatives to inform refugees of their entitlements and that the health care facilities do not provide interpreters for refugees.[147]

In support of the HRW findings, an empirical study carried out earlier by the CSVR (2001) found that:

1. There was a marked discrepancy between known contraceptive methods and actual usage; Knowledge about existing family planning services was low;
2. Less than half of the respondents reportedly knew where the nearest family planning clinic was;
3. There was low knowledge about the main causes of sexually transmitted infections; and

[147] For example the report points out that many refugees rely on the intervention of advocates so as to obtain access to emergency care.

4. Although the general awareness about HIV/Aids in particular was slightly higher, specific knowledge about transmission routes and preventive strategies was alarmingly low.

In addition, Whitall[148] of MSF has noted that the country lacks targeted information on HIV and AIDS in numerous languages available in the country (The Body 2008).

Not only do refugees lack knowledge on vital information that would enable them to access healthcare services, but also there is empirical evidence that points to the fact that most of refugees are oblivious of the existing mechanisms of seeking redress. Empirical evidence in a study carried out by Belvedere (2003) indicated that only 1 per cent of refugees who were refused health services lodged a complaint and 24 per cent reported doing nothing, largely because they did not know what to do.

It is important for refugees to fully appreciate their rights as an entitlement. In cases where refugees are unable to comprehend important details such as information on HIV/AIDS, measures should be put in place to convey the information in a language that they can understand. Where refugees are knowledgeable about mechanisms for seeking redress, they feel more empowered to assert their rights. Therefore refugees should be enlightened on these issues.

5.2.2 Dissemination of Information to Health Staff.

Unfortunately, current practice suggests that the directives issued by the DOH are ignored by healthcare workers. According to the HRW report, the DOH is to blame. It

[148] Jonathan Whittall MSF programmes director.

has failed to fully inform health care workers about the existing refugee treatment policies and to provide guidelines or to educate them on how to interpret assorted forms of non-citizen identifications or the fee schedule used for migrant patients (2009:9). In addition, the DOH has failed to systematically collect health surveillance information on migrant and mobile populations. This would be important in predicting and providing for refugees' health needs (HRW 2009: 9).

The COMRSA has also observed that there are only a few departments or public service providers that have adequate policies and customs accommodating refugee rights. It attributes this to the lack of coordination, either by the DOH or by the cluster of department representatives (2008, 8). Consequently there have been reports on incidents where hospital staff have denied refugees access to health care due to their inability to recognise various existing refugee documents and ignorance on existing refugee rights under the law and policies(LHR:2008).

Such reports are a clear reflection on the states' failure to take "*other measures*" for the full realisation of this right. Achieving full realisation of refugee right to access healthcare requires that healthcare services are effective and efficient. Consequently, healthcare officials need to be well versed with the rights of refugees. It is essential for healthcare officials to possess a better knowledge of all refugee rights in the context of patients' rights.

5.3 Barriers to Emergency Care for Rape Survivors:

Rape and HIV/AIDS are a great concern in South Africa as the country has high levels of sexual crimes and the country is one of the fastest-growing HIV epidemics

in the world (Kim et al 2003). Reports on refugees' rape incidents especially as they cross the Zimbabwe-South Africa border have increased. For example the HRW report (2009) gives an account of Zimbabwean rape victims' cases that it has encountered.[149] Similar stories have been documented by the MSF.[150]

A study on women preference for services after rape (Christofides et al 2006) indicates that rape survivors need a holistic post-rape care. They particularly valued the availability of PEP (Post Exposure Prophylaxis) and a sensitive health care provider to provide counselling. Despite the various reported incidents of rape, concerns have been raised by refugee rights activists on the level of accessibility of healthcare services availed to refugee rape survivors. According to the HRW (op.cit:9) such rape survivors are unable to access meaningful counselling and treatment available nationally.[151] I

Some of the reasons given by rape survivors for not accessing healthcare services are:

1. Language barriers;
2. Lack of information and knowledge of the available services ;
3. Fear of maltreatment and denial from accessing healthcare services; and
4. Fears of deportation as some providers require them to report the incidents to the police (HRW 2009:9).[152]

Important to this issue is the Sexual Offenders (Criminal Law Sexual Offences Amendment Bill) Act (2007). s 28 (1) provides for provision of PEP at public health

[149] See HRW (2009: 35-39).
[150] See MSF (n.d).
[151] This would include HIV diagnosis, provision of post-exposure prophylaxis (PEP).
[152] See MSF (n.d).

establishments to rape victims subject to the victim laying charges or reporting the incident at a designated health establishment. Therefore, the National health policy gives priority to meeting the needs of the survivor, whether or not they report to the police.

As rape victims have a 72 hours window period in which they can receive preventative treatment for HIV infection, such barriers that refugee rape survivors experience are a threat to a rape survivor's health and life. Therefore such barriers would be in breach of s 27(3) of the Constitution.

A rape victim's circumstances fall within s 27(3) of the Constitution (1996) as was observed in the *Soobramoney* case.[153] This is because the occurrence of a rape incident is sudden or unexpected; a victim does not have the opportunity to make prior arrangement for the required treatment; and there is urgency of securing the post-exposure prophylaxis (PEP) treatment in order to prevent HIV infection.[154]

However, inequalities in PEP health service do not exist only in matters of refugee rape survivors. Empirical evidence in a study carried out by Escott Et al (2005) indicate that the implementation of equitable HIV services in South Africa is particularly challenged, given the inequities that already existed in the general public health system. In addition, a study by Jewkes and Abrahams (2002) has observed that the vast majority of rapes go unreported and only a small proportion of women attend health care services after rape, with many believing that their actions will not lead to punishment for the perpetrator.

[153] Soobramoney's case supra.
[154] PEP can only be effective within 72 hours window period, the earlier PEP treatment is given to rape survivor the better.

5.4 *Legal Fees*

There have been reports of incidents where refugees have been charged excessive fees in contravention of the DOH policy (HRW 2009: 9). The HRW (Ibid) also attributes this to the existence of a complicated user fee system in the public sector which fluctuates from 20-100% of the total cost of healthcare, as is determined by the source of income and type of care.

These incidents contravene the DOH policy and s 4(3)(b) NHA which requires that public healthcare providers should provide free primary health care service to all persons, subject to any condition prescribed by the Minister.[155] In addition the Committee on Economic Social and Cultural Rights recommends that payment for healthcare services should be based on the principle of equity, ensuring that the services are affordable for all, including socially disadvantaged groups (General Comment 14 Para 12(b) (iii).

Despite initiatives from the DOH, it can be deduced from the above discussion that unfortunately the state still has a long way to go in fulfilling its international, regional and national obligation towards refugees and healthcare services. The difficulties explained are not a result of a weak legal regime in South Africa but are due to unconstitutional, unethical and illegal acts.

Moreover the CERD has reminded states of their obligations towards non-citizens. It obliges them to remove obstacles that prevent enjoyment by non-citizens of their rights to health and to respect their right to adequate standards of health by *inter*

[155] The only class of people exempted from such services are members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases.

alia refraining from denying or limiting their access to preventive, curative and palliative health services.[156]

In addition, states under article 12 of the ICESCR have a duty to prevent third party violation of this right. Third party violators include individuals and legal persons (Leckie 1998: 108).[157] Since this obligation extends to the state's responsibility to regulate third parties behaviours,[158] South Africa is duty-bound to put in place measures that will regulate the public healthcare staff and other citizen's behaviours and altitudes that may contribute to the refugees' denial to healthcare access.

[156] See Gen. Recommendation 30, Para 29 & 36.
[157] See Second Interim report on the question of the impunity of perpetrators of human rights violations (1996).
[158] See Dankwa, Flinterman & Leckie (1998: 714) and for cooperate responsibility see Chapham and Rubio (n.d).

Chapter 6 – Implications of the Denial for Refugees to Access Healthcare

As a result of the difficulties that refugees face in accessing healthcare services, there is a tendency to seek help from the NGO sector (FMS 2008). This creates a dual health system which may strain the health NGO sector resources, as most of the NGOs are dependent on donor funds (Ibid). In addition, refugees may also shun healthcare services. This may increase refugees' morbidity and mortality and therefore threaten their right to life or to be healthy.

In addition the difficulties experienced may affect the healthcare profession-patient relationship. Refugees may loose trust on health workers and consequently may not disclose pertinent information that may be necessary to treat them or aid the DOH in controlling diseases. Some other implications include:

1. Refugees significantly benefit the host countries. They contribute in state building and are a source of the state's revenue as tax payers (Jacobsen 2003:596). However since health is a determinant of economic growth and poverty, unhealthy and ill refugees may be unable to work or may not fully realise their potential in their work place.

2. In addition this may further strain the states resources. This is because if refugees are left untreated, then their illness may worsen until a point is reached that it will cost the state even more than would have been the case if the illness was treated in its initial stages.

3. Where a refugee has an infectious disease, he/she may spread the disease and cause an outbreak. In such cases therefore, the state may spend more trying to control the outbreak than it could have spent if such a refugee received treatment at the onset.

For example where a refugee patient has Tuberculosis (TB), failure to treat the disease would pose a threat to the public's health as Tuberculosis is air borne.[159] This would also frustrate the public health system's effort to contain the disease. This is because the need to contain TB places major demands on surveillance systems. In addition, it is well known that Tuberculosis (TB) and HIV represent a deadly duo. Tuberculosis (TB) remains the most common co-infection in HIV-infected subjects in South Africa.[160] Thus in a country where HIV/AIDS prevalence is high like in South Africa, such an outbreak would be an ongoing concern as it predicts extreme vulnerability to tuberculosis as progressive HIV suppresses the immune system and hence makes the HIV/*AIDS* infected person more vulnerable to TB.

Further, where refugees have an infectious disease the morbidity and mortality of the whole society (including refugees) would be increased. The situation could be exacerbated by the fact that South African refugee policies encourage integration. Any public health effort to control and prevent the spread of an outbreak would be futile, as diseases know no nationality.

[159] For it to be transmitted, person infected need only cough, spit, talk or sneeze. This then propels TB germs known as Bacilli in the air, and an uninfected person just needs to inhale a small amount of these germs.
[160] See Umesh G. L. And *Pillay s. 2008.* Managing Tuberculosis and HIV in Sub-Sahara Africa. Current HIV/AIDS Reports 5**:** 132 – 139.

4. Where diseases are left untreated (for reasons that refugee patients are denied health care services or they shun healthcare services) such actions can have dire consequences. For example in case of HIV, non-adherence may cause viral load to go up and the CD4 count to go down within a short time.[161]

In other situations, the untreated disease may develop resistance to drugs and the organisms may become highly virulent or toxic. To illustrate this, let's take the case of Tuberculosis (TB). Where a refugee patient does not other adhere to treatment, it may likely led to MDR-TB. Where MDR-TB is not treated it may result to XDR-TB[162], as XDR TB is an indirect indicator of program failure to adequately diagnose, prevent, and treat MDR TB.[163] The implications of such a scenario would be:

- More expensive to cure: The drugs used in treatment of MDR-TB and XDR-TB are expensive and the treatment requires extensive chemotherapy for up to two years.[164]
- Patients needed strict monitoring to ensure adherence. This requires hospitalization for about two years.
- The drugs used for treatment have toxic side effects.

[161] This could also happen without non-adherence.
[162] XDR tuberculosis is caused by a strain of *Mycobacterium tuberculosis* resistant to isoniazid and rifampin (which defines MDR tuberculosis) in addition to any fluoroquinolone and at least one of the three following injectable drugs: capreomycin, kanamycin, and amikacin.
[163] Drug resistant TB is a man made problem and is primarily a consequence of sub optimal TB control. Improper treatment of drug-resistant TB, such as using too few drugs, relying on poor quality second-line drugs, and failing to ensure adherence to treatment, will likely lead to increases in XDR TB. See Shah N.S, Wright A, Bai G, et al. (2007).
[164] To bring the figures closer to home; medical treatment of XDR-TB can cost US$ 500,000. See Selgelid, M. McLean R. Arinaminpathy N. et al (2009).

- Second line drugs are less effective than are the first-line drug used to cure ordinary TB: despite treatment only 30%-40% of XDR-TB patients survive.[165] MDR-TB and XDR-TB are *'a likely death sentence*' (London 2008).

Ensuring that refugee patient are able to exercise their right to access health care services would be one way of strengthening basic TB programs and infection control measures (among others). This would be critical for preventing the selective pressure and environments in which resistant strains are transmitted from person to person.[166]

[165] In the preliminary analysis of European patients, have shown higher probability of death and worse outcome in XDR-TB cases compared to MDR-TB see Miglio G B, Ortmann J,Girardi E, et al.(2007)in Selgedi op.cit.

[166] See Lambregts-van Weezenbeek & Reichman (2000). A commentary published in 2000 it predicted that "*failure to institute [the] entire DOTS-Plus package is likely to destroy the last tools available to combat [TB], and may ultimately result in the victory of the tubercle bacillus over mankind.*"

Chapter 7 – Recommendations and Conclusion

From the previous chapters it can be concluded that the existing policies governing refugees' rights to access health care in South Africa are well grounded. The state as a promoter and protector of refugees right to health have failed to fully meet its obligations as discussed in chapter 1, 2 and 3 so as to ensure that refugees have the full enjoyment of this right. This amounts to a violation of refugees right to health as envisaged in the Maastricht Guidelines.[167]

The failure of the state to effectively promote, protect and fulfil refugees' right to access healthcare services in South Africa cannot be attributed to the nature of obligations and rights as established under international, regional and national laws. The problem lies on implementation of these policies: the implementation is weak. As observed by Leckie (1998: 81) '*It is a problem of perception and resolve*'.

By virtue of the fact that South Africa has become a party to the main human rights international treaties, its constitution and the enactment of the Refugee Act, which specifically provides for the refugee right to access healthcare services, it therefore can be argued that the government has made a commitment to pay greater attention to refugees' health. Therefore, all hope is not lost for refugees as legislative measures do exist to back up their claims.

There is need to put into place comprehensive tracking and monitoring mechanisms to ensure that the government decisions are fully implemented at national and

[167] See Para vii (3) it stipulates that a state violation of the right to health will occur if a significant number of people are deprived of essential primary health care.

regional levels. Accordingly, the need also arises for the government to work for the change of behavioural attitudes of South Africans towards refugees. This may be done by creating awareness of refugee rights in general within the community. In order to effectively convert refugees' rights to entitlements, the enlightenment process should go beyond specific health care rights and should extend to all other rights that are related to these rights e.g., the right to access information, freedom from discrimination and the right to equality.

Other ways I suggest that the government could work on to support the rights of refugees to health care services, are the following:

1. The DOH should initiate reporting, accountability, or enforcement strategies by health care facilities to ensure implementation of existing refugees' policies (HRW: 2009). This can be done by :

- Incorporating human rights monitoring into the work of health professions, professional bodies, health staff and health establishment. In doing so the state will guard against xenophobic and other forms of discriminatory attitudes towards refugees.
- Secondly the DOH should initiate refugees' rights awareness programmes for training all staff working in the public health facilities. In addition refugee issues should be incorporated in the training curriculum of students in health institutions (COMRSA 11:2008).
- The DOH should put into place monitoring mechanisms to ensure that refugee policies that are passed, are effectively communicated and implemented to all concerned, down to the front desk of the hospital staff. For example the FMS (2008) recommended that the national government

should be lobbied to ensure that public facilities management pay attention to directives from the DOH. In addition the MHF (2008) recommends that the DOH should audit all institutional level policies on refugees to ensure compliance with national level directives.

- Lastly, although if refugees are considered as patients by the hospital staff, there would be no problem, a reminder of the group's vulnerability in the form of a poster or statement might be helpful as a reminder that all patients should be treated with dignity.

2. Empowering refugees. This can be done by:

- Greater participation: The DOH should liaise with refugee groups or the Coordinating Body of Refugees in policy making, implementation and monitoring. In addition this organisations or groups can be used as forums to air their healthcare grievances.
- Availing refugees with information necessary for them to fully realise their rights to access healthcare. The refugee groups can also be used to enlighten refugees on their rights to access healthcare. For example the MFM (2008) suggests that the DOH can establish helpdesks in public hospitals, where it can even recruit from the refugee communities.
- The state through the DHA should assist refugees in the integration process. Most refugees depend on the assistance of UNDHR and local people for their survival and hence find it difficult to access healthcare services (Dunbar-Oritze & Harrell-bond: 1987, 110).[168]

[168] For a detailed discussion on refugees' integration see Local Integration and Self-Reliance- Iii. Role of Self-Reliance. Executive Committee Of The Ec/55/Sc/Crp.15 High Commissioner's Programme Standing Committee 2 June 2005, 33rd Meeting

- The DOH should recruit interpreters from the refugee' communities (HRW: 2009).

3. With regard to scarcity of resources, there arises a need to rethink ways of achieving health rights in Africa (Abudullahi 2001).These include:
   - Using Independent research findings that provide cost effective, efficient and sustainable interventions (Africa Health Strategy: 2007 – 2015 ,62)
   - Recruit health professions from the refugee communities to fill the human resource gaps in the health sector. In addition, subject to the availability of resources, the state could encourage refugees to pursue health related courses by giving them sponsorship.[169]
   - The DOH should liaise with the various government departments to ensure full realisation of this right, as health is a developmental issue requiring a multi-sectoral response.

4. If resources permit the state may develop a service model for primary health care that would deal with specific refugees' health risks such as TB and Cholera among other needs.[170]

The above recommendations do not require the state to go beyond the parameters set under the national and international laws '*to progressively realise'* refugees' right as regard to healthcare services, but to do what is within its means and power to

[169] Africa Health Strategy: 2007 – 2015 observes that: While Africa has 10% of the world population; it bears 25% of the global disease burden and has only 3% of the global health work force. Of the four million estimated global shortage of health workers one million are immediately required in Africa.
[170] See Ager, A. and Strang, A. (2008: 173).

remedy the injustices visited upon them. If this is done, then refugees' rights can be eventually be converted to entitlements

Bearing in mind that, s 7(1) of the Constitution stipulates that the Bill of Rights is a cornerstone of democracy and that subsection 2 obliges the state to respect, promote and fulfil the rights in the Bill of Rights. South Africa should move expeditiously and effectively as possible towards a full implementation of refugee health policies in line with the principles of availability, acceptability, quality and acceptability. Such implementation will depend on the resources available for health purpose and will be subject to distributive justice. However, with regard to refugees' emergency healthcare there is a need to meet the obligations immediately as any denial would render the existing policies meaningless.

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