Exploring the Psychosocial & Health Rights of Forced Migrants in Johannesburg

The impact of “daily stressors” on the emotional wellbeing of forced migrants

SEPTEMBER 2011 REPORT
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Forced migrants experience challenges in accessing healthcare

“They only talk to you in their language and laugh at you. If you say: please sister help me. They replied to you: don’t call me sister. I am not your sister because I am a South African and you are not a South African like me.”

CSVR client

“I had terrible headaches and I went to [XXXX] clinic. They checked me and didn’t find anything. They said I wasn’t sick. The best medication for me to get better was to go back to my country. That would heal me. They just gave me Panado. I went back there a month later; it was the same story, asking me to go back to my home country.”

CSVR client

Considering “psychosocial”

“The term alone explains that psychological well-being cannot exist without social well-being, and vice versa. Forced migrant health is dependent on looking at both in order to support the individual. The two are not mutually exclusive and although our role is mostly psychological support we know that we cannot fully support the individual unless we are looking at the social aspects of his/her life.”

CSVR staff member

“The psychosocial means everything leading to improve people’s lives: jobs, justice (foreigners’ access to loans and other advantages as South Africans), and access to proper documentation.”

CSVR client

Addressing the psychosocial and health needs of forced migrants

“I feel at home here and after counselling session I am a bit relieved of my burdens. But I can’t be totally healed as long as I still face hunger, poverty, lack of proper documentation and my son’s health decay.”

CSVR client

“If we wish to contribute to the development of policy to improve health, the complex combinations of social, psychological and biological processes that contribute to ill-health need to be clarified.”

(Martikainen, Bartley, & Lahelma, 2002: 1093)
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Executive Summary

South Africa has a progressive, integrative, urban refugee policy that encourages forced migrants – refugees and asylum seekers – to self-settle and integrate. Unlike other countries, there are no refugee camps in South Africa; forced migrants are not afforded any special support from the government. The South African Constitution (The Republic of South Africa, 1996) and the Refugee Act (The Republic of South Africa, 1998), affords particular rights through protective legislation to refugees and asylum seekers. This includes the right to employment and access to social services, including free basic healthcare. More recent legislation has confirmed that this includes access to free basic healthcare and free ART for both refugees and asylum seekers - with or without a permit (NDOH, 2007a). However, many challenges are experienced by refugees and asylum seekers when attempting to access healthcare, and other services; protective policies have not transformed into protective practices (for example, see CoRMSA, 2011; IOM, 2010; Landau, 2006; Moyo, 2010; Vearey, 2008a; Vearey, 2011a).

Some forced migrants experience mental health problems, linked to experiences of trauma in their country of origin, on their journey to South Africa, and/or within South Africa itself (Bandeira, Higson-Smith, Bantjes, & Polatin, 2010). Neuropsychiatric conditions are ranked 3rd in South Africa’s burden of disease (after HIV/AIDS and other infectious diseases); despite this, mental health resources are “chronically under-resourced” with only 28% of people with moderate – severe common mental disorders receiving mental healthcare (Burns, 2011). Very little research has been undertaken to explore forced migrants’ access to psychosocial and mental health services. In response to this, a research study was undertaken to explore the psychosocial and health rights of forced migrants in Johannesburg who currently receive trauma counselling and support from the Trauma Clinic of the Centre for the Study of Violence and Reconciliation (CSVR), a non-governmental organisation (NGO) located in the inner-city. The study involved documenting and analysing the experiences of forced migrants in accessing their health and psychosocial rights, with a focus on their emotional wellbeing.

We understand health as being a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948). In this context, health rights involve access to positive determinants of health, including healthcare, adequate nutrition and food security. We consider psychosocial rights to be those rights afforded to forced migrants that relate to their social and psychological well-being, including emotional wellbeing, to live free of violence and discrimination, and to access to safe and secure housing.

This study involved a literature and policy review; a survey with 40 Trauma Clinic clients; semi-structured interviews with a subset of 9 clients; and, interviews and group discussions with clinic staff and representatives of partner organisations that refer forced migrants for counselling. Additionally, a participatory policy workshop was held with a range of stakeholders to discuss emerging findings and the implications of these findings to upholding the health and psychosocial rights of forced migrants in Johannesburg. We interviewed documented refugees and asylum seekers from the Democratic Republic of Congo, Zimbabwe, Rwanda, Somalia, Congo Brazzaville, Burundi and Angola. A number of South African clients were also interviewed.

Urban forced migrants in Johannesburg are found to face specific challenges in accessing public healthcare, including services for mental health and psychosocial support. The forced migrants that we interviewed access
trauma counselling at the CSVR and were referred there by other non-governmental organisations providing support to forced migrants. In addition to challenges in accessing public healthcare, the respondents in our survey were found to experience specific “daily stressors” that are associated with being a forced migrant, including problematic access to documentation; insecure livelihood activities; fear of violence; a lack of trust in the police; poor food security; challenges in accessing healthcare (including mental health services); discrimination by public sector officials; language barriers; inadequate shelter; and, problems in accessing schooling for their children. These “daily stressors” negatively affect the emotional wellbeing of urban forced migrants, adding to any pre-existing trauma or emotional distress. This results in an increased demand for mental health and psychological support in a context where public access to these services is problematic.

“Daily stressors” are stressful social and material conditions that are caused by social marginalisation, isolation, inadequate housing and changes in family structure. Existing research demonstrates that “daily stressors” effect psychological well-being (Miller & Rasmussen, 2010). During their counselling at the CSVR, the role of “daily stressors” in mediating the emotional wellbeing of forced migrants becomes apparent.

Our research supports existing evidence that mental ill-health is strongly associated with poverty and the social deprivation associated with poverty (Burns, 2011). Some daily stressors are common to South African citizens who are also reliant on public healthcare, whilst others are unique to urban forced migrants. Whilst many of these “daily stressors” are also experienced by South African nationals – and we acknowledge the context of urban inequality present in Johannesburg – particular stressors are unique to the non-national status of forced migrants. Both staff and clients acknowledge the negative role of “daily stressors”. We believe that addressing the causes of these “daily stressors” will improve the emotional well being of urban forced migrants in Johannesburg.

The study findings presented in this report support prior research indicating that policies designed to protect urban forced migrants are not being effectively implemented in Johannesburg. Our research shows that this results in urban forced migrants experiencing multiple “daily stressors” that negatively affect their emotional wellbeing, increasing their demand for psychological support. The survey and interviews with staff and clients indicate that urban forced migrants who are seeking counselling and support for trauma require additional psychological support to address the “daily stressors” they experience. Our overriding recommendation is to transform existing protective policy for urban forced migrants into protective practices as this will remove various “daily stressors”.

Currently, non-governmental services are doing their best to “fill the gap” in access to public sector mental health and psychosocial support services by providing counselling to forced migrants. Additionally, a range of Johannesburg-based non-governmental organisations are working to assist forced migrants in accessing their rights relating to access to social and health services. Our research indicates that there is an urgent need to address the causes of the “daily stressors” faced by forced migrants within interventions that aim to improve their mental health and emotional well-being. This will involve assisting forced migrants to access their psychosocial rights; it is essential that stressful social and material conditions are improved in order to improve the emotional wellbeing of forced migrants –thus reducing their mental health needs (Miller & Rasmussen, 2010).
Introduction

This report presents the findings of a study undertaken by the African Centre for Migration & Society (ACMS) in collaboration with the Centre for the Study of Violence and Reconciliation (CSVR). Prior research undertaken by ACMS clearly indicates that forced migrants experience challenges in accessing public healthcare and other social services. The effect of these negative experiences on the emotional wellbeing of forced migrants in urban South Africa is currently unknown.

Since the late 1990s, as part of its Trauma and Transition Programme (TTP), the CSVR has been counselling refugees and asylum seekers from various African countries who had experienced violent conflict in their home countries and/or xenophobic violence in South Africa (Bandeira, Higson-Smith, Bantjes et al., 2010). Whilst CSVR – as a non-governmental organisation – provides counselling and will work to refer individuals into specialist mental healthcare within the public sector should it be required, knowledge relating to the experiences of urban forced migrants in accessing public mental health care is limited. Previous research undertaken by the CSVR has highlighted the range of additional challenges that forced migrants who are accessing trauma counselling face.

“It highlights some of the contextual factors that negatively impact on the recovery process of this group, which clinical interventions will need to take into consideration. It is clear that therapeutic work with refugee victims of torture in South Africa is complex and the extreme contextual factors will impact on clinical interventions provided.”

(Bandeira, Higson-Smith, Bantjes et al., 2010: 103).

It is with this in mind that this report aims to develop a greater understanding of the contextual factors that present ongoing stress to urban forced migrants who have experienced trauma and are currently receiving support at the CSVR. Through this research, we are also able to consider the experiences of urban forced migrants in trying to access mental healthcare in Johannesburg. The findings and recommendations presented aim to improve access to health and psychosocial rights for forced migrants in Johannesburg.

Defining health and psychosocial rights

We understand health as being a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948). In this context, health rights include access to healthcare and to positive determinants of health, such as adequate nutrition and food security. We consider psychosocial rights to be those rights afforded to forced migrants that relate to their social and psychological well-being, including emotional wellbeing, to live free of violence and discrimination, and to access to safe and secure housing.

Aims and objectives of the report

The aim of the study is to explore and understand the extent to which the psychosocial and health rights of forced migrants who currently receive support from the CSVR are being upheld.

The following specific objectives will contribute towards achieving the overall research aim:

- To review the national and international legislation and treaties outlining the psychosocial and health rights of (1) nationals and (2) forced migrants in South Africa.
To document the experiences of both South African and forced migrant clients who receive support from the CSVR in accessing their psychosocial and health rights.

To explore the migration trajectories of clients receiving support from the CSVR.

To determine how clients receiving support from the CSVR overcome challenges they may face in accessing their psychosocial and health rights.

To document the experiences of CSVR staff in working with clients to uphold their psychosocial and health rights.

**Methodology**

This study involved (1) a literature and policy review; (2) a survey with CSVR clients (n = 40); (3) in-depth interviews with CSVR clients (n = 9); (4) interviews and focus group discussions with CSVR staff (n = 7); and (5) semi-structured interviews with representatives of partner organisations (n = 3).

Interviews and surveys were conducted in the respondents’ language of choice. The research team spoke English, French, Lingala and Portuguese. Where necessary, CSVR assisted in providing interpretation for respondents.

Additionally, a participatory workshop was held with 24 stakeholders involved in working to uphold the health and psychosocial rights of forced migrants. This workshop included a presentation of the emerging study findings, including the literature and policy review. A policy brief – that aims to guide civil society/ies response - was collectively generated (see Appendix 1). This brief has been adapted to generate a briefing note that can be shared with a wider group of stakeholders. A report of the workshop is also available.

**Limitations**

This research involved only a small sample of refugees and asylum seekers who are currently receiving counselling for trauma at the CSVR. Whilst we had initially designed the survey to capture a total of 200 respondents, it was clear once the fieldwork commenced that this would not be possible. Despite having understood that there would be 200 clients to access, it took almost 2 months to access just 40. Therefore, our sample size is too small to undertake any significance tests, or tests of association. However, the data does enable us to tell a detailed story about the experiences of CSVR clients. All of the respondents reported that they currently hold the documentation required to be within South Africa legally, and the majority of respondents were female. Therefore, the findings presented in this report are not generalisable to the experiences of all forced migrants within urban South Africa. However, the findings do give a clear indication of the sorts of challenges forced migrants who require support for trauma face, and how these challenges impact their emotional well being.

**Ethics**

The ACMS research team worked with CSVR to ensure that ethical principles would be upheld during the study. Ethical approval for the study was granted by the Wits Research Ethics Committee (non-medical), protocol number H110246. The research team has experience in working with vulnerable migrant groups, including refugees and asylum seekers who have experienced trauma.
Understanding the health and psychosocial rights of forced migrants in Johannesburg

This section of the report provides an overview of the literature and policy review. Drawing on existing research, this section clearly outlines that – despite the existence of protective legislation - challenges are faced by forced migrants in attempting to access their health and psychosocial rights. In this section, we also discuss how we understand both health and psychosocial, laying the foundation for how the empirical data is discussed in the following section.

An introduction to migration in South Africa

Globally, 740 million people are today estimated to have moved within their countries of birth (internal migrants), and 214 million people – just over 3% of the world’s population - are estimated to be international migrants (those who have crossed borders) (UNDP, 2009). Whilst the relationship between migration and health is acknowledged to be complex, migration is recognised as a central determinant of health, requiring appropriate policy and programme responses (Anarfi, 2005; MacPherson & Gushulak, 2001).

Recently, migration and health have received renewed attention through the 2008 World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (Ghent, 2008; World Health Assembly, 2008). The Resolution calls upon member states to ensure the health of migrant populations, through a range of actions including: promoting migrant-sensitive health policies; promoting equitable access to health promotion, disease prevention and care for migrants; establishing health information systems in order to assess and analyse trends in migrants’ health; gather, document and share information and best practices for meeting migrants’ health needs in countries of origin or return, transit and destination; and promoting bilateral and multilateral cooperation on migrants’ health among countries involved in the whole migratory process (World Health Assembly, 2008). Whilst recognising that this high level policy commitment was made only recently, multiple challenges to ensuring the health of both internal and international migrant populations persist (AIDS & Rights Alliance for Southern Africa, 2008; Amon & Todrys, 2009; CoRMSA, 2009; Forced Migration Studies Programme, 2009; Harper & Raman, 2008; Human Rights Watch, 2009a, 2009b).

South Africa is associated with diverse historical and contemporary migration configurations, including the oscillating rural – urban movements of individuals seeking improved livelihood opportunities in urban and peri-urban areas and – increasingly - cross-border migration (Collinson, Wolff, Tollman, & Kahn, 2006; Landau & Wa Kabwe Segatti, 2009; Lurie, 2006). Whilst popular estimates of the cross-border migrant population within South Africa vary considerably, analysis of national census and community survey data suggest that there are approximately 1.6 million cross-border migrants in South Africa, which (in line with global trends) equates to 3.4 per cent of the total South African population (CoRMSA, 2009).

Migration into South Africa has consistently increased since the end of apartheid (Landau & Wa Kabwe Segatti, 2009) and previously “forbidden cities” (Landau, 2005: 1115) such as Johannesburg have become a destination for people from across the country, the continent and beyond. As a result, cross-border migrants in South Africa tend to be concentrated in urban areas. Within Gauteng, the most migrant-dense – and
economically active – province of South Africa, about 5 to 6 per cent (around 58,000 people) of the population are estimated to be cross-border migrants (Landau & Wa Kabwe Segatti, 2009; UNOCHA & FMSP, 2009). In comparison, almost 3.9 million South Africans living in Gauteng have migrated from another province within the county (UNOCHA & FMSP, 2009). There are different categories of cross-border migrants present in South Africa – as in other countries around the world – with many possessing a range of temporary visitor permits including work and study permits (Landau & Wa Kabwe Segatti, 2009). A small, but important number, are refugees and asylum seekers: individuals who have been forced to flee their own countries and are seeking safety in South Africa (Vearey, 2008a). In this research, ‘refugee’ is used to describe an individual who has been granted asylum and is in possession of a refugee status permit (section 24 permit). The term ‘asylum seeker’ is used to refer to an individual seeking refuge that is in possession of an asylum seeker permit (section 22 permit). ‘Undocumented’ is used to describe individuals who currently lack the documentation required to be in South Africa legally.

Urban forced migrants

South Africa has a progressive, integrative, urban refugee policy that encourages forced migrants – refugees and asylum seekers – to self-settle and integrate. Unlike other countries, there are no refugee camps in South Africa; forced migrants are not afforded any special support from the government. The South African Constitution (The Republic of South Africa, 1996) and the Refugee Act (The Republic of South Africa, 1998), afford particular rights through protective legislation to refugees and asylum seekers. This includes the right to employment and access to social services, including free basic healthcare. Whilst the UNHCR urban policy has been critiqued for not providing sufficient support to refugees and asylum seekers, it does provide some guidance for host countries in outlining the rights of refugees and asylum seekers located in urban areas. This is highlighted below.

“These rights include, but are not limited to, the right to life; the right not to be subjected to cruel or degrading treatment or punishment; the right not to be tortured or arbitrarily detained; the right to family unity; the right to adequate food, shelter, health and education, as well as livelihoods opportunities.”

“Given the need to prioritize its efforts and allocation of resources, UNHCR will focus on the provision of services to those refugees and asylum seekers whose needs are most acute. While these priorities will vary from city to city, they will usually include:

- providing care and counselling to people with specific needs, especially people with disabilities, those who are traumatized or mentally ill, victims of torture and SGBV, as well as those with complex diseases requiring specialized care.”

(UNHCR, 2009: 18)

Migration and health: Implications for urban forced migrants

Whilst the relationship between migration and health is acknowledged to be complex, migration is recognised as a central determinant of health, requiring appropriate policy and programme responses (Anarfi, 2005; MacPherson & Gushulak, 2001). In the southern African region, migration is associated with asylum seeking, and for many poor households, migration represents a key livelihood-seeking strategy. Ensuring and sustaining the good health of populations is a critical development challenge within the southern African
region, both at national and regional levels. Exploring migration – including forced migration - through a public health lens highlights a range of tensions that need to be overcome in order to strengthen public health responses, including those of public healthcare systems, for all within the region. Responses do not currently engage equitably with all population groups and migrants, particularly cross-border migrants, experience challenges in accessing public healthcare systems in southern Africa.

Historically, within the southern African region, the context of migration places those that move at increased risk of a range of negative health outcomes. This mostly results from an inability to access positive social determinants of health, which are defined as “the full set of social conditions in which people live and work” (Commission on the Social Determinants of Health, 2007). It is not being a migrant per se that increases health risks, but the context associated with being a poor migrant. Positive social determinants of health include: the health system; food and nutrition security; adequate housing and tenure; access to safe water and sanitation; secure livelihood activities; social networks and family support.

All of these determinants are affected by the socioeconomic and political context, including factors associated with governance and policy (WHO, 2008). Migrants, both internal and cross-border, may be excluded from accessing preventative and curative care (through legislation, or through challenges in accessing services), and may reside in unhealthy spaces where health risks are high. Cross-border migrants have been shown to face challenges in accessing the health system (itself recognised as a central determinant of health), resulting in delayed medical care and treatment. It is the social and political context - in this case the marginalisation, xenophobia and fear of violence faced by urban forced migrants in Johannesburg - that results in differential exposures to health-damaging conditions, differential vulnerabilities to illness, and differential consequences of ill-health.

It is important to emphasise that the health of migrant populations is about more than their access to public healthcare services alone: as outlined above, the health of migrants is determined by their (in)ability to access positive determinants of health. Available evidence suggests that migrant populations are often unable to access positive determinants of health, shown to be a result of the existing discrimination and marginalisation faced by urban forced migrants, and the lack of protective practice. This produces a context that can lead to negative health outcomes, which present an additional, yet avoidable, burden at the population health level.

**Mental health and psychosocial well being**

As stated previously, we consider psychosocial rights to be those rights afforded to forced migrants that relate to their social and psychological well-being, including emotional wellbeing, to live free of violence and discrimination, and to access to safe and secure housing. We apply the definition of psychosocial as

> “pertaining to the influence of social factors on an individual’s mind or behaviour and to the interrelation of behavioural social factors.”

(Oxford English Dictionary)

These factors have an effect on health as they mediate, condition or modify the effects of socio structural factors on individual health outcomes. We also consider the psychosocial determinants of health as this allows us to capture the extent to which health is affected by psychosocial determinants - this is a critical aspect to be considered when thinking through access to broader psychosocial and health rights (Martikainen, Bartley, & Lahelma, 2002). The schema presented in figure 1 below usefully outlines the different layers of social and psychosocial factors that lead to a health outcome. This ties in with the concept of social determinants of health.
Existing literature demonstrates how “daily stressors” negatively effect the emotional well being of individuals, including those who have previously experienced a traumatic event (Miller & Rasmussen, 2010). “Daily stressors” are stressful social and material conditions that are caused by social marginalisation, isolation, inadequate housing and changes in family structure – such as losing a spouse or moving away from supportive family structures.

Existing research demonstrates that “daily stressors” affect psychological well-being (Miller & Rasmussen, 2010); this is outlined in figure 2 below. Based on their research, Miller & Rasmussen (2010) argue that daily stressors mediate the relationship between exposure to armed conflict (and associated trauma) to mental health and psychosocial status. Importantly, they highlight that there are likely to be two types of daily stressors: (1) those that are caused or worsened by armed conflict and (2) those that are unrelated to armed conflict. This is a useful suggestion for how mental health is affected not only by prior traumatic events, but by daily stresses experienced after the exposure to war/other trauma.

**Figure 2: Daily stressors as partially mediating the relationship of armed conflict to mental health and psychosocial status.**
Neuropsychiatric conditions are ranked 3rd in South Africa’s burden of disease (after HIV/AIDS and other infectious diseases); despite this, mental health resources are “chronically under-resourced” with only 28% of people with moderate – severe common mental disorders receiving mental healthcare (Burns, 2011). When considering the South African situation generally, Burns (2011) describes what he calls “the mental health gap in South Africa – a human rights issue”. This is in response to the fact that despite the burden of mental health being great with South Africa, appropriate health systems and social responses are lacking – for all, including forced migrants (Burns, 2011). This presents a challenge to those involved in addressing the psychosocial and mental health needs of forced migrants in South Africa. Miller and Rasmussen (2010) usefully outline four key actions that they believe will lead to improving mental health and psychosocial well being. These are outlined in Table 1 below.

These four actions helpfully outline the importance of undertaking an assessment of the “daily stressors” present within a given context, and to develop interventions to assist in addressing these stressors before beginning with other psychosocial support. Importantly, they highlight that interventions must engage with diverse forms of distress (i.e. go beyond post traumatic stress disorder – PTSD) and that it is essential to acknowledge that not all forms of trauma are related to exposure to war, for example, domestic violence or rape outside of a war context. Other, underlying sources of emotional distress may exist including the negative impact of underlying “daily stressors”.

### Table 1: Improving mental health and psychological well being

1. It is important to undertake a **rapid and contextually grounded assessment of locally salient daily stressors** before developing mental health and psychosocial interventions.

2. Before providing specialised clinical services that target psychological trauma, **first address those daily stressors that are particularly salient and can be affected through targeted interventions**.

3. When specialised mental health interventions are indicated, **interventions should go beyond PTSD to address the diverse forms of distress** that may result from exposure to war-related violence and loss.

4. It is essential to take into account that **not all symptoms of trauma are necessarily related to conflict exposure**. Even in situations of armed conflict, there are other sources of psychological trauma.

(Miller and Rasmussen, 2010)
Legislation and guidelines: A global overview

Recent reviews provide a useful overview of the health rights of international migrants, including refugees and asylum seekers (IOM, 2009a, 2010, 2011; IOM, 2009b; WHO, 2010). The most important international resolution relates to the 61st annual World Health Assembly (WHA) adopted Resolution 61.17 on the Health of Migrants, which calls on member states (including South Africa) to promote equitable access to health promotion, disease prevention and care for migrants (World Health Assembly, 2008). Various global, regional and national meetings have been held in order to discuss the WHA, including: the 2009 Migration Dialogue for Southern Africa (MIDSA); the March 2010 Global Consultation on Migrant Health in Madrid, Spain; and, a two-day national consultation convened in April 2010 on migration and health in South Africa. Recommendations from these meetings include the need to improve referrals between healthcare institutions (both within countries and across borders); develop “health passports” for internal and regional movement; ensure support is provided to rural healthcare systems and households of origin; and to provide ongoing training and support to healthcare providers (Vearey, 2011a).

“From an international human rights law perspective, migrants and mobile populations have a right to health regardless of their immigration status. Article 16 of the African Charter on Human and People’s Rights (ACHPR, 1986) and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1990) grant every individual the right to enjoy the best attainable state of physical and mental health, regardless of the documentation they do (not) hold.

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (GA, 1990) stipulates that all migrant workers and their families have the right to emergency medical care for the preservation of their life or the avoidance of irreparable harm to their health (article 28). Such care should be provided regardless of any irregularity in their stay or employment. The Convention further protects migrant workers in the workplace and stipulates that they shall enjoy treatment not less favourable than that which applies to nationals of the state of employment in terms of work, safety and health. South Africa has not ratified this convention and is urged to do so.”

(IOM, 2010: 34)

Health and migration: the legislative framework in South Africa

In South Africa, different categories of international migrants are granted differential rights to access free public healthcare services. Legislation indicates that refugees and asylum seekers should be treated as South African citizens in terms of access to free public health care (The Republic of South Africa, 1998). Other non-citizen groups (such as those with work or study permits) should be charged a ‘foreign fee’ at the point of use. However, the multiple pieces of legislation and guidelines can prove confusing. Section 27 of the South African Constitution (1994) guarantees ‘access to health care for all’ (The Republic of South Africa, 1996). The National Health Act (2003) and the Constitution assures everyone in the country - regardless of immigration status - access to life-saving care (The Republic of South Africa, 1996, 2003). The Refugees Act (1998) provides particular rights to legally recognised refugees (The Republic of South Africa, 1998).

It is therefore frustrating that ambiguity relating to the rights of non-citizen groups to accessing public health services, including antiretroviral treatment (ART), has prevailed (UNHCR & AIDS & Human Rights Research Unit University of Pretoria, 2006; Vearey, 2008a). The different documents that non-citizens may hold (e.g.
refugee, asylum seeker, and the range of temporary residence permits) present challenges to service providers who may not be familiar with different documentation. In addition, national guiding documents – such as the 2007 – 2011 National Strategic Plan (NSP) for HIV & AIDS and STIs – use the terms ‘asylum seeker’, ‘refugee’ and ‘foreign migrant’ interchangeably, which is an additional source of confusion for practitioners (NDOH, 2007b).

South Africa began to roll-out a free national ART programme in the public health sector in April 2004. Attempts to clarify ambiguity relating to the rights of international migrants to access ART have been made. For example, the latest NSP (2007 – 2011) specifically includes non-citizen groups (NDOH, 2007b). A key guiding principle to the successful implementation of the 2007 – 2011 Plan is towards “ensuring equality and non-discrimination against marginalised groups”; refugees, asylum seekers and foreign migrants are specifically mentioned as having “a right to equal access to interventions for HIV prevention, treatment and support” (NDOH, 2007b: 56). Importantly, Priority area 4 of the Plan encompasses human rights and access to justice, with goal 16 being to ensure “public knowledge of and adherence to the legal and policy provision” (NDOH, 2007b: 119).

Furthermore, prior to the 2007 national plan, in early 2006 the National Department of Health (NDOH) issued a statement clarifying that patients do not need to be in possession of a South African identity booklet in order to access ART (NDOH, 2006). This has implications not only for international migrants but also for undocumented South Africans. Additional guidelines have been developed in collaboration between the Southern African HIV Clinicians Society and the United Nations High Commissioner for Refugees (UNHCR), supplementing the NDOH ART guidelines, to guide ART provision for international migrants, asylum seekers and refugees (Southern African HIV Clinicians Society & UNHCR, 2007). As a result of the lobbying of civil society groups, and the UNHCR, a more recent (September 2007) Financial Directive from the NDOH confirms that refugees and asylum seekers - with or without a permit – have the same right as South Africans to access free basic healthcare and ART in the public sector (NDOH, 2007a).

In 1997, two important documents were produced that relate to mental healthcare – the White paper for the transformation of the health system in South Africa and National health policy guidelines for improved mental health in South Africa. However, these policies were not published or widely circulated, and no implementation guidelines developed. The Mental Health Care Act of 2002 was promulgated in 2004. This Act is in line with international human rights standards and includes mechanisms for decentralisation and integration of mental health. However, the act was never costed or implemented (Burns, 2011; Lund & et al., 2010). The fact that these policies have not been implemented or costed is detrimental to the emotional wellbeing of South Africans and forced migrants alike.

Whilst some existing policies, directives and guidelines may prove confusing to healthcare providers, it is important that the basic rights to healthcare for forced migrants are reiterated within the public healthcare system in South Africa: refugees and asylum seekers have the same rights to access healthcare as South African citizens. This is clearly outlined in the 2007 Directive, within the Constitution and in the Refugees Act. As for South African citizens, this includes free primary healthcare, free ART and to be means tested the same as South African nationals for any hospital-based care. Like South African citizens, refugees and asylum seekers who are not working will be exempt from payment of fees. However, with the development of a National Health Insurance (NHI) policy in South Africa, we urge the South African government to ensure that cross-border migrant groups – including forced migrants – are able to access free primary healthcare, including ART. The current Green Paper suggests that the rights of non-nationals to access free care will be removed.
Migrant access to healthcare in South Africa

Despite the development of the policy guidelines and frameworks outlined above, and albeit that they have been developed relatively recently, many challenges continue to be experienced by international migrants when they attempt to access public health services in South Africa, as protective policy has not been effectively transformed into protective practices (Amon & Todrys, 2009; CoRMSA, 2009; Human Rights Watch, 2009a, 2009b; Landau, 2006; Pursell, 2004; Vearey, 2008b; Vearey, 2011a).

This includes some frontline public healthcare providers demanding documentation from cross-border migrants and – often through not understanding the documentation presented – not providing care to individuals who are without a South African identity booklet. Whilst some of the existing guidelines prove confusing, the 2007 Directive, the Refugee Act and the Constitution are clear on the rights of refugees and asylum seekers; these clearly stipulated rights of refugees and asylum seekers are not being implemented. In addition to the lack of policy application, cross-border migrants struggle to communicate with healthcare providers (translators are not present).

Whilst we are aware that South African clients may also face challenges in accessing healthcare providers who speak their home language, cross-border migrants are more effected. Some public health facilities have been found to generate their own guidelines and policies that counter national legislation; continuing to demand South African identity documents and denying access to international migrants (CoRMSA, 2009; Vearey, 2008a).

An additional problem that has already been highlighted, is the inability of some forced migrants to obtain the necessary documentation to be in South Africa legally, due to poor implementation of the asylum process - access to documentation through the Department of Home Affairs is problematic for all migrants, including refugees and asylum seekers (CoRMSA, 2009; Landau, 2006; Vearey, 2008a).
Key Findings

This section of the report presents the empirical findings from the client survey and interviews, interviews and focus group discussions with CSVR staff, and interviews with representative partner organisations. The empirical data supports existing literature/research, and assists in demonstrating the negative impact of “daily stressors” on the emotional well being of forced migrants in Johannesburg.

Profile of clients and experiences of accessing health and psychosocial rights in Johannesburg

Forty clients participated in the survey. As shown in Figure 3 below, the majority of participants reported that they originated from the DRC. The second largest group were Zimbabweans.

Figure 3: The majority of participants originated from the DRC

As displayed in figure 4 below, the majority of survey respondents were female; only 9 out of 40 respondents were male. This pattern was replicated in the in-depth interviews where only 1 out of 9 respondents was male. This was not due to refusal rates but was linked to the profile of the current CSVR client pool, who were found to be mostly female.
The age of respondents was quite well distributed but it is important to note that the average age of the respondents was higher than often seen for other migrant groups who have participated in previous migration research in Johannesburg. This is shown in figure 5.

Figure 4: The majority of survey respondents were female

Figure 5: Age distribution of participants
As shown in figure 6, all participants reported to be documented. The majority reported to be asylum seekers. However, during the survey interviews – and interviews with staff and partner organisations – access to documentation was a common challenge shared and discussed. It is possible that some individuals may be without documents, but this could be related to having lost documents (or having experienced them destroyed by the police). We did not ask respondents to show us any documentation so we cannot verify this.

Figure 6: All participants reported to be documented

The majority of respondents reported that they were residing in either a flat or a house (see figure 7). However, it is important to note that participants were residing with many others within their residence; flats and houses were subdivided. Many respondents spoke of the challenges that they experienced in finding sufficient money for rent, finding shelter, and the conditions of the housing that they resided within. Concerns raised linked to privacy, and associated safety. These pressures are examples of “daily stressors” experienced by respondents.

“I live in a small room with my 17-year-old son and 16-year-old daughter. It is really overcrowding. Sometimes we have problems to dress on in the morning after bathing and we are forced to do everything in the bathroom for the sake of modesty.”

(Clara, Congo Brazzaville)
Respondents identified a range of livelihood strategies, ranging from making popcorn, to baby sitting, to braiding hair and to undertaking piece work. Figure 8 indicates that survey respondents have insecure access to a livelihood: strategies are not secure and only 4 respondents reported being employed. It is important to note that these respondents were either South African or held a temporary resident permit. Despite refugees and asylum seekers having the right to work (and be employed) in South Africa, in this small survey, refugees and asylum seekers are dependent on informal sector work.

“Now I am having a problem of high blood pressure. My feet are swollen as I used to walk for long distances to beg for food for my children.”

Clara, Congo Brazzaville

“As means of living I sell at this time winter clothes (hats, gloves, etc.) and I clean people’s houses. This requires me to walk for long distances and it is causing me pain in my knees and back.”

Alice, Angola

“My life is mostly affected financially. I don’t have any means to support myself and my children. One of my children is dropping the school this month because I don’t have money to pay for her fees.”

Tambudzai, Zimbabwe
Despite possessing documentation, respondents highlighted that documentation does not necessarily improve or guarantee access to healthcare.

“It is almost everywhere in South African system. When you have this asylum permit, even when you have the rights to be assisted, it stops you from getting assistance you need. It is just assists for not being arrested by the police but not in the hospitals.’

Survey respondent

Most of the clients are referred to CSVR by organisations or institutions such as Bienvenu shelter or Lawyers for Human Rights (LHR) that deal with cross-border migrants. Clients reported that CSVR is a place where they feel welcome and encouraged to tackle life in South Africa. Respondents reported that counselling contributes positively to their well-being, despite their challenging living conditions.

“I am even healed by the fact of coming here. I was depressed and didn’t understand what was going on in my body. Counselling made me understand the situation I was going through and why it did happen to me. The counsellor encourages me to stand by myself. She gave me that spirit to understand the situation in which I was, where I come from and how to move forward. Before I couldn’t stay with you like this. I was always crying and getting angry and I didn’t like people around me.”

Tambudzai, Zimbabwe
“When you go to public hospitals, they don’t look at you as a human being because you are a foreigner. But with CSVR you just feel welcome. You feel home away from home. That’s the word I put with CSVR. For me it is home away from home. You meet people who are like a family to you. This is something that you don’t see elsewhere.”

Kholi, Zimbabwe

Twenty one respondents reported receiving support from NGOs, including CSVR. This support included food, money, goods (clothes) and shelter. However, the majority of respondents reported being dissatisfied with the support they receive.

“Sometimes I receive material support in terms food, clothes and transport money from CSVR. For example yesterday I went to Home affairs; CSVR gave me money to pay transport for the whole family.”

Alice, Angola

Access to public health care presents a persistent “daily stressor”; whilst the majority of respondents report that they do access healthcare, multiple challenges are experienced. These challenges mostly relate to discrimination, causing ongoing fear, shame and embarrassment to clients. Almost half of respondents reported that they felt that healthcare workers are not attentive enough.

“The [Doctor at the hospital] said to me: “You foreigners, you are bringing your dirty illnesses to this country. You don’t deserve treatment in South Africa because your country doesn’t contribute even with a cent to medical care in this country. Stop overcrowding our hospitals with your dirty sicknesses and go back to your country.”

Lisa, DRC

“At [XXX], the doctor didn’t address me well. She said that there was no malaria and no medication to treat malaria in South Africa; that I should go back to Burundi otherwise I would die here”.

Survey respondent

“They've [healthcare providers] got attitude toward foreigners and always ask us to go back to our country.”

Survey respondent

Just over half of survey respondents felt discriminated against in public healthcare facilities.

“They will ask you when you are going back to your home country. They are rude and disrespectful.”

Survey respondent

“They only talk to you in their local language and ask you to go back to your country.”

Survey respondent

“They always ask me to go back to my country with my problem.”

Survey respondent
One third of respondents reported that they had experienced stigma within public healthcare facilities.

“I felt like I was talking to them about something funny. Because they talked to each other and started laughing.”

Survey respondent

“They only talk to you in their language and laugh at you. If you say: please sister help me. They replied to you: don’t call me sister. I am not your sister because I am a South African and you are not a South African like me.”

Survey respondent

“They called me names and were asking me to go back to my country in front of a lot of people.”

Survey respondent

However, some respondents indicated that accessing care is not the problem, it is the experience of accessing care and the way that they are treated within the facility.

“Accessing health care is not really hard but that attitude towards foreigners is troubling. One example, at [XXXX] Hospital the nurse was talking to me in Sotho. I speak Zulu but I don’t understand Sotho. When I asked her to explain to me either in Zulu or in English, she asked me, ‘Where are you from?’ when I said I was from Zimbabwe she replied, ‘You are from Zimbabwe and you are HIV positive. Do you think you have to come here to spoil us with your disease?’”

Kholi, Zimbabwe

A South African respondent spoke clearly about the problems with the healthcare system itself. We are aware that if individuals attempt to access healthcare at the wrong point in the system, they will be turned away. It is essential for all who need care to access care at the right level, normally at a primary healthcare level.

“You know, a migrant who stays in Johannesburg and goes to [XXXX] Hospital for treatment won’t be turned back to Johannesburg without getting treated. But a South African Sowetan who goes to [XXXX] Hospital for treatment is going to be turned back to Soweto. A South African lady felt badly treated at [XXXX] Hospital in front of immigrants because she was from Soweto. But she demanded to be treated. That’s why South African citizens don’t like foreigners. They think that they take all their advantages. But this is caused by the government because their system is not properly working. They don’t even know the number of migrants in South Africa.”

Zuki, South Africa

It is clear that access is improved if facilitated by CSVR, or another non-governmental organisation.

“If you go on your own access is hard. They don’t consider you; you can spend the whole day there. Sometimes they chase you away. But if you bring a letter from an organisation like CSVR they treat well. In 2007 I was referred by CSVR to [XXXX] Clinic at mental health service and I was taken there by [CSVR staff member].”

Clara, Congo Brazzaville

“CSVR referred me to [XXXX] Clinic. They received me very well and continue to treat me until now. There is an improvement.”

Alice, Angola
“When you have a letter with Home Affairs by these days, something like a letter from people who know you, such organisations confirming who you are and what your problem is, you are at least given attention. I got that letter from CSVR saying that I am their client and how long they know me, what my problem was. The letter was certified by the LHR. When I took that letter to Home Affairs, I was considered, respected and I had my asylum permit the same day thanks to CSVR.”

Kholi, Zimbabwe

One South African respondent referred to the importance of clients being confident in standing up for their rights.

“They usually check the person because if they are in front of a person who knows how to stand for his/her rights, then they afraid and try to treat him/her differently. Most of the time people like that are not many and black people are afraid to speak or protect their rights.”

Sibongile, South Africa

Twenty eight respondents reported having experienced violent crime in Johannesburg; only 17 sought assistance. Survey respondents were very clear about why they did not report the crime to the police.

“We thought it wouldn’t help as they don’t care for foreigners in South Africa.”

Survey respondent

“I knew the police would not help because they have got negative attitude toward foreigners.”

Survey respondent

Language clearly presented an ongoing challenge and daily stress to respondents.

“I don’t know English very well, even Sotho or Zulu. Sometimes they insult me because I don’t know how to speak these languages.”

Survey respondent

“They talk to you in a language you don’t understand (Tswana). If you say you don’t understand, they reply: “This is South Africa.” If you ask them some explanation in English, then they ask you: Are you a white?”

Survey respondent

“They didn’t give me time to express myself knowing that my English was not perfect.”

Survey respondent
Conclusions & Recommendations

“The counsellor is renewing my life, my strength and power to be somebody else. But at the government level, we need shelter, education for our children and small grant to manage to survive with kids.”

Tambudzai, Zimbabwe

This research has shown that individuals access CSVR for trauma counselling and are referred to the CSVR by other non-governmental organisations that provide support – legal advice, shelter, money – to refugees and asylum seekers. Individuals are referred for counselling relating to prior trauma. During counselling, the role of “daily stressors” in mediating their emotional wellness becomes apparent; both staff and clients acknowledge the negative role of “daily stressors”. It is evident that addressing these “daily stressors” will improve the emotional well being of urban forced migrants in Johannesburg. Staff, representatives from partner organisations and CSVR clients identified “daily stressors” – in the main part – as being related to an ineffective translation of protective policy into protective practice, indicating that urban forced migrants struggle to access their health and psychosocial rights.

Data collected from the interviews show that the living conditions of migrants are challenging. CSVR clients experience daily stressors resulting from the lack of a secure (reliable) livelihood, documentation, accommodation, and the inability to meet their basic needs. These daily stressors negatively affect their health and well-being. Additionally, accessing health care and psychosocial support is difficult; whilst many reported being able to access public healthcare, it is clear that refugees and asylum seekers experience discrimination within these public spaces, presenting an additional “daily stressor”. This presents an ongoing stress as forced migrant clients are unwilling to put themselves into situations where they are laughed at and feel discriminated against. As a result, it is very difficult for participants to access medication consistently and efficiently. Both South Africans and forced migrants have negative experiences of accessing health care especially in public health care institutions; this report highlights that there is an urgent need to improve public healthcare access for all within South Africa. A focus on improving access for all who reside within South Africa will improve access for forced migrants. CSVR is described as a place of hope and trust. They provide professional services and people feel welcome and are given space to talk.

However, the counselling provided by CSVR will not successfully address the mental health challenges of refugees and asylum seekers as they continue to face challenges in terms of accessing documentation, livelihoods, food security and paying their children’s school fees. While migrants acknowledge the role of CSVR in supporting and counselling them, they think that the government should be involved in promoting their well-being. The promotion of well-being includes the promotion of justice in responding to their basic needs.

“The psychosocial means everything leading to improve people’s lives: jobs, justice (foreigners’ access to loans and other advantages as South Africans), and access to proper documentation.”

Alice, Angola

Burns (2011) suggest 8 areas for action to improve mental health in South Africa – for both South African nationals and non-nationals. These are useful and our research supports these action areas. The 8 areas are presented in table X below.
Table 2: Eight suggestions for addressing mental health in South Africa

1. A strong advocacy movement led by persons with mental disabilities.
2. Legislative reform to abolish discrimination, outlaw abuse and exploitation and protect personal freedom, dignity and autonomy.
3. Legislative reform to inform equality of opportunity, access and participation in all aspects of life.
4. Inclusion of mental disability on the agenda of development programmes and targets such as Millennium Development Goals (MDGs).
5. Mental health and social services reform with equitable funding for resources, infrastructure, and programmes development.
6. Removal of barriers to access to health services encountered by persons with mental disabilities.
7. Removal of barriers to access to social, family-related, accommodation, educational, occupational and recreational opportunities, and full participation for persons with mental disabilities.
8. Service system reform to move away from institutional care toward providing treatment, care, rehabilitation and reintegration within the community.

(Burns, 2011: 108 - 109)

The overriding recommendation is to transform existing protective policy for forced migrants into protective practices. This can be supported as follows:

- Contribute to ongoing advocacy efforts - led by CoRMSA and partners - to address the challenges forced migrants face in accessing their health and psychosocial rights in South Africa. This involves highlighting how the inability to access the asylum system and documentation has a profound effect on the mental health and emotional well-being of forced migrants.

**HOW?** Researchers should share empirical evidence relating to the challenges faced by forced migrants in accessing their health and psychosocial rights that will contribute to ongoing advocacy efforts led by CoRMSA.

- Join and engage with existing mental health advocacy movements to highlight the mental health and psychological needs of forced migrants. This must include advocating for the costing and implementation of the South African Mental Health Act (2002).

**HOW?** Encourage existing forced migrant advocacy and research networks to join larger national and international movements that are advocating for improved responses to mental health, including The World Federation for Mental Health and the Movement for Global Mental Health. This includes engaging with – and mobilising - MSF South Africa
(who are committed to campaigning for the mental health rights of migrants), the Johannesburg Migrant Health Forum, the Forced Migration Protection Working Group and the Consortium for Refugees and Migrants in South Africa (CoRMSA).

**Recommendations to the National Department of Health**

- Provide appropriate training at the provincial, local (metro), district and facility levels on migration and health, incorporating the health and psychosocial rights, and mental health needs of forced migrants. This involves engaging with the multiple government departments involved in migration and health.

  **HOW?** A training intervention has been developed and piloted that aims to improve migrant access to healthcare in South Africa (IOM and ACMS). This training could be modified to incorporate a specific session on psychosocial rights, and the mental health needs of forced migrants, and delivered at facility, metro and provincial levels. Frontline staff, medical personnel and management should participate in these change and action-oriented trainings. Provincial and metro health departments will need to take a lead on this and ensure that colleagues in social development and home affairs participate.

- Strengthen the distribution, awareness, implementation and monitoring of existing protective legislation relating to the health and psychosocial rights of forced migrants.

  **HOW?** Through existing structures within the health system. Additionally, there is a need for provincial and metro health directors to ensure that every facility has copies of all existing legislation, that these directives are distributed within a facility, and that they are displayed within a facility – for both staff and clients. It is essential that provincial and metro health departments run monitoring visits to all facilities to ensure that existing legislation is being implemented. This will require engagement with Public Relation Officers at each facility.
References


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Towards improving forced migrant access to health and psychosocial rights – a focus on Johannesburg

Problem statement

In South Africa, the general population experiences poor access to public healthcare, including mental healthcare and psychosocial services. Urban forced migrants in Johannesburg are found to face specific challenges in accessing their right to healthcare, including services pertaining to mental healthcare and psychosocial support. Additionally, some urban forced migrants experience specific “daily stressors” that negatively affect their emotional wellbeing. These “daily stressors” are linked to their status as non-nationals and include access to documentation, livelihoods, food security, housing, and schooling. Research indicates that policies designed to protect urban forced migrants are not being effectively implemented in Johannesburg.

Background of the problem

Over the last four years, the Consortium for Refugees and Migrants in South Africa (CoRMSA) has provided evidence-based updates on the challenges faced by migrant communities that restrict their access to public healthcare services in South Africa (CoRMSA 2007, 2008, 2009, 2011). These problems persist. Although undocumented migrants face the greatest challenges in accessing public healthcare services, those with documentation also experience problems in accessing basic healthcare, including antiretroviral treatment (ART). Evidence suggests that, compared to South African citizens, foreign migrants are worse affected by the challenges linked to financial and human resource constraints in the public healthcare system, particularly the frustrations of interacting with frontline healthcare providers. In addition, CoRMSA raises concern that the planned end to the moratorium on the deportation of undocumented Zimbabweans in mid-2011 will negatively impact access to public health and continuity of treatment for HIV and tuberculosis as migrants fearing arrest, detention and deportation will avoid public hospitals and other healthcare services.

Policy context

In 1997, two important documents were produced – the White paper for the transformation of the health system in South Africa and National health policy guidelines for improved mental health in South Africa. However, these policies were not published or widely circulated, and no implementation guidelines developed. The Mental Health Care Act of 2002 was promulgated in 2004. This Act is in line with international human rights standards and includes mechanisms for decentralisation and integration of mental health. However, the act was never costed or implemented (see Lund et al., 2010 and Burns, 2011).

governed by the Refugee Act (1998). This Act provides particular rights to legally recognised refugees, including access to healthcare (Republic of South Africa 1998). As a result of the lobbying of civil society groups, and the UNHCR, a more recent (September 2007) Financial Directive from the NDOH confirms that *refugees and asylum seekers, with or without a permit, have the same right as South Africans to access free basic healthcare and ART in the public sector* (NDOH 2007). Despite the existence of these directives, many challenges continue to be experienced by international migrants when they attempt to access public health services in South Africa, as protective policy has not been effectively transformed into protective practices (see Vearey, 2011).

**Policy recommendations**

The overriding recommendation is to transform existing protective policy for forced migrants into protective practices. This can be supported in four key ways:

1. **Contribute to ongoing advocacy efforts - led by CoRMSA and partners - to address the challenges forced migrants face in accessing their rights in South Africa.** This involves highlighting how the inability to access the asylum system and documentation has a profound effect on the mental health and emotional well-being of forced migrants.

   **HOW?** Share empirical evidence relating to the challenges faced by forced migrants that will contribute to ongoing advocacy efforts led by CoRMSA.

2. **Provide appropriate training at the provincial, local (metro), district and facility levels on migration and health, incorporating the psychosocial and mental health needs of forced migrants.** This involves engaging with the multiple government departments involved in migration and health.

   **HOW?** A training intervention has been developed and piloted that aims to improve migrant access to healthcare in South Africa (IOM and ACMS). This training could be modified to incorporate a specific session on the psychosocial and mental health needs of forced migrants, and delivered at facility, metro and provincial levels. Frontline staff, medical personnel and management should participate in these change and action-oriented trainings. Provincial and metro health departments will need to take a lead on this and ensure that colleagues in social development and home affairs participate.

3. **Strengthen the distribution, awareness, implementation and monitoring of existing protective legislation relating to the health and psychosocial rights of forced migrants.**

   **HOW?** This can be incorporated into recommendation one. Additionally, there is a need for provincial and metro health directors to ensure that every facility has copies of all existing legislation, that these directives are distributed within a facility, and that they are displayed within a facility – for both staff and clients. It is essential that provincial and metro health departments run monitoring visits to all facilities to
ensure that existing legislation is being implemented. This will require engagement with Public Relation Officers at each facility.

4 Join and engage with existing mental health advocacy movements to highlight the mental health and psychosocial needs of forced migrants. This must include advocating for the costing and implementation of the South African Mental Health Act (2002).

**HOW?** Encourage existing forced migrant advocacy and research networks to join larger national and international movements that are advocating for improved responses to mental health, including The World Federation for Mental Health and the Movement for Global Mental Health. This includes engaging with – and mobilising – MSF South Africa (who are committed to campaigning for the mental health rights of migrants), the Johannesburg Migrant Health Forum, the Forced Migration Protection Working Group and the Consortium for Refugees and Migrants in South Africa (CoRMSA).

**Key references**


Appendix 2: Drafted briefing note

Towards improving forced migrant access to health and psychosocial rights – a focus on Johannesburg

This issue brief is a quick reference guide regarding forced migrant access to their health and psychosocial rights in Johannesburg. We consider ‘forced migrants’ to include recognised refugees and asylum seekers, as well as individuals who may currently be without documents but describe themselves as seeking asylum. We understand health as being a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948). In this context, health rights include access to healthcare and to positive determinants of health, such as adequate nutrition and food security. We consider psychosocial rights to be those rights afforded to forced migrants that relate to their social and psychological well-being, including emotional wellbeing, to live free of violence and discrimination, and to access to safe and secure housing.

Drawing on collaborative research conducted with the Centre for the Study of Violence and Reconciliation (CSVR), our research clearly identifies that whilst forced migrants are afforded a range of rights – including health and psychosocial rights - they face challenges in accessing these rights. These challenges manifest as a range of specific “daily stressors” that negatively affect their emotional wellbeing, thus highlighting the challenges forced migrants face in accessing their psychosocial rights. “Daily stressors” are stressful social and material conditions that can be linked to social marginalisation, isolation, inadequate housing and changes in family structure. Existing research demonstrates that “daily stressors” affect psychological well-being (Miller and Rasmussen, 2010). Our research shows that the “daily stressors” faced by forced migrants in Johannesburg relate to challenges in accessing psychosocial rights, including: challenges in accessing documentation; insecure livelihood activities; fear of violence; poor food security; challenges in accessing healthcare (including mental health services); inadequate shelter; a lack of trust in the police; and, problems in accessing schooling for their children.

This issue brief – based on our own research and developed through a participatory process with multiple stakeholders - highlights that policies designed to protect the health and psychosocial rights of urban forced migrants are not being effectively implemented in Johannesburg. This results in urban forced migrants experiencing multiple “daily stressors” that negatively affect their emotional wellbeing, increasing the demand for psychological support.

Background of the Problem

Globally, urban centres are increasingly home to forced migrant populations. South Africa has an integrative asylum policy, requiring asylum seekers and refugees to self-settle and integrate in cities such as Johannesburg. Forced migrants are afforded a range of rights, including those to protect their health and psychosocial well-being. Some forced migrants have experienced traumatic events – in their country of origin, during their migration journey, or in the country/city of destination – that may result in specific mental health and psychological needs. However, our research highlights that urban forced migrants in Johannesburg face specific challenges in accessing their right to health, including services pertaining to mental healthcare and psychological support. Over the last four years, the Consortium for Refugees and Migrants in South Africa
(CoRMSA) has provided evidence-based updates on the challenges faced by migrants when attempting to access public healthcare services in South Africa. These challenges include language problems, access being denied on the basis of documentation or for “being foreign”, and problematic interactions with frontline healthcare providers.

In addition to challenges in accessing healthcare, our research findings indicate that urban forced migrants experience specific “daily stressors” – associated with being a forced migrant, including problematic access to documentation; basic services; shelter, and livelihood opportunities. These “daily stressors” negatively affect their emotional wellbeing, adding to any pre-existing trauma or emotional distress. This results in an increased demand for mental health and psychological support in a context where access is problematic.

There is an urgent need to address “daily stressors” within interventions that aim to improve the mental health and emotional well-being of forced migrants. This involves assisting forced migrants to access their psychosocial rights. It is essential that stressful social and material conditions are improved (Miller and Rasmussen, 2010).

The Relevant Policy Context

Section 27 of the South African Constitution (1994) guarantees ‘access to health care for all’ (Republic of South Africa 1996). The National Health Act (2003) and the Constitution assures everyone in the country, regardless of immigration status, access to life-saving care (Republic of South Africa 1996, 2003). Different migrant categories are afforded differential rights in South Africa. Forced migrants – refugees and asylum seekers – are governed by the Refugees Act (1998). This Act provides particular rights to legally recognised refugees, including access to healthcare (Republic of South Africa 1998). As a result of the lobbying of civil society groups, and the UNHCR, a more recent (September 2007) Financial Directive from the NDOH confirms that refugees and asylum seekers, with or without a permit, have the same right as South Africans to access free basic healthcare and ART in the public sector (NDOH 2007). Despite the existence of these directives, many challenges are experienced by forced migrants when they attempt to access public health services in South Africa, as protective policy has not been effectively transformed into protective practices (see Vearey, 2011).

In 1997, two important documents were produced – the White paper for the transformation of the health system in South Africa and National health policy guidelines for improved mental health in South Africa. However, these policies were not published or widely circulated, and no implementation guidelines have been developed. The Mental Health Care Act of 2002 was promulgated in 2004. This Act is in line with international human rights standards and includes mechanisms for decentralisation and integration of mental health. However, the act was never costed or implemented (see Lund et al., 2010 and Burns, 2011). The fact that these policies have not been implemented or costed is detrimental to the emotional wellbeing of South Africans and forced migrants alike.

Recommendations to civil society

The overriding recommendation is to transform existing protective policy for forced migrants into protective practices. This can be supported as follows:

Contribute to ongoing advocacy efforts - led by CoRMSA and partners - to address the challenges forced migrants face in accessing their health and psychosocial rights in South Africa. This involves highlighting how
the inability to access the asylum system and documentation has a profound effect on the mental health and emotional well-being of forced migrants.

**HOW?** Researchers should share empirical evidence relating to the challenges faced by forced migrants in accessing their health and psychosocial rights that will contribute to ongoing advocacy efforts led by CoRMSA.

- Join and engage with existing mental health advocacy movements to highlight the mental health and psychological needs of forced migrants. This must include advocating for the costing and implementation of the South African Mental Health Act (2002).

**HOW?** Encourage existing forced migrant advocacy and research networks to join larger national and international movements that are advocating for improved responses to mental health, including The World Federation for Mental Health and the Movement for Global Mental Health. This includes engaging with – and mobilising - MSF South Africa (who are committed to campaigning for the mental health rights of migrants), the Johannesburg Migrant Health Forum, the Forced Migration Protection Working Group and the Consortium for Refugees and Migrants in South Africa (CoRMSA).

### Recommendations to the National Department of Health

- Provide appropriate training at the provincial, local (metro), district and facility levels on migration and health, incorporating the health and psychosocial rights, and mental health needs of forced migrants. This involves engaging with the multiple government departments involved in migration and health.

**HOW?** A training intervention has been developed and piloted that aims to improve migrant access to healthcare in South Africa (IOM and ACMS). This training could be modified to incorporate a specific session on psychosocial rights, and the mental health needs of forced migrants, and delivered at facility, metro and provincial levels. Frontline staff, medical personnel and management should participate in these change and action-oriented trainings. Provincial and metro health departments will need to take a lead on this and ensure that colleagues in social development and home affairs participate.

- Strengthen the distribution, awareness, implementation and monitoring of existing protective legislation relating to the health and psychosocial rights of forced migrants.

**HOW?** Through existing structures within the health system. Additionally, there is a need for provincial and metro health directors to ensure that every facility has copies of all existing legislation, that these directives are distributed within a facility, and that they are displayed within a facility – for both staff and clients. It is essential that provincial and metro health departments run monitoring visits to all facilities to ensure that existing legislation is being implemented. This will require engagement with Public Relation Officers at each facility.
References


Miller, K. and Rasmussen, A. (2010) War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks Social Science and Medicine 70(1) 7-16


## Appendix 3: Cross-border migrant right to health

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>LEGISLATION</th>
<th>DOCUMENTS HELD</th>
<th>RIGHT TO HEALTHCARE / CONDITIONS</th>
</tr>
</thead>
</table>
| Asylum seeker         | • Refugee Act  
• Constitution  
• National Health Act  
• 2007 Financial Directive | Section 22 Permit | • Same as South African citizens  
• Free emergency care.  
• Free primary healthcare, including ART  
• Means tested the same way as South African citizens |
| **An individual who has submitted an asylum application at a Refugee Reception Office (RRO) (part of Home Affairs)** | | | |
| Refugee               | • Refugee Act  
• Constitution  
• National Health Act  
• 2007 Financial Directive | Section 24 permit | • Same as South African citizens  
• Free emergency care.  
• Free primary healthcare, including ART  
• Means tested the same way as South African citizens |
| **An individual who has been granted asylum. This process can take years. In the meantime, individuals hold asylum permits. Note that the majority of asylum applications are rejected.** | | | |
| Study permit          | • Immigration Act  
• Constitution  
• National Health Act | Various permits within passport | • Free emergency care.  
• Liable for a foreign fee.  
• Individuals with study and work permits normally require medical aid.  
• If without medical aid, free primary healthcare should be provided. |
| Work permit           |                                                                             | | |
| Visitors permit       |                                                                             | | |
| Undocumented          | • Constitution  
• National Health Act  
• 2007 Financial Directive | Currently not in possession of documentation. This can be for a range of reasons. | • Free emergency care.  
• If a refugee or asylum seeker without a permit: free primary healthcare, including ART. |
To: Provincial HAST Managers
    Provincial CCMT Project Managers:

Dear All

RE: ACCESS TO COMPREHENSIVE HIV & AIDS CARE INCLUDING ANTI RETROVIRAL TREATMENT

The Comprehensive HIV & AIDS Care, Management and Treatment Operational Plan was approved by parliament in November 2003 and implementation commenced in April 2004. The programme has brought challenges in all provinces regarding access to treatment by patients who do not possess a South African Identity Document.

The criteria used to identify patients eligible for ART must be applied to all cases, individually without discrimination. Issues that can affect adherence and hence compromise patient's health must be seriously considered, so that the decision to commence ART is the best for the patient under all circumstances.

Patients should not be denied ART because they do not have an ID if all issues affecting adherence have been addressed and the treatment team is convinced that the patient stands to benefit from the intervention.

Thank you,

Dr. ND Kalombo
Project Manager: Comprehensive HIV & AIDS Care, Management and Treatment Plan.
NDOH.

CC: Dr. R Kundu
Cluster Manager: HIV & AIDS, STI and TB
MEMORANDUM

TO: ALL HOSPITAL CEO’S, DISTRICT FAMILY PHYSICIANS AND DISTRICT MANAGERS.

DATE: 04 APRIL 2008

SUBJECT: ACCESS TO THE COMPREHENSIVE HIV AND AIDS CARE INCLUDING ANTIRETROVIRAL TREATMENT.

It has come to my notice that some facilities are denying patients that do not have a South African Identity document access to the comprehensive HIV and Aids care, management and treatment plan including antiretrovirals. This practice is not acceptable.

Kindly note that no patient should be denied access to any health care service, including access to antiretrovirals irrespective of whether they have a South African Identification document or not.

For reference please see attached memorandum.

DR. PMH MADUNA
CHIEF DIRECTOR
REGION A
REVENUE DIRECTIVE - REFUGEES/ASYLUM SEEKERS WITH OR WITHOUT A PERMIT

To: PROVINCIAL HEALTH REVENUE MANAGERS
HIV/AIDS DIRECTORATES

19TH SEPTEMBER 2007

Dear All

HOSPITAL FEES: ASSESSMENT OF REFUGEE / ASYLUM-SEEKERS
(with or without a permit)

Preamble

REFUGEE ACT, Act No. 130 of 1998 (Chapter 5; Section27, (g))

RIGHTS AND OBLIGATIONS OF REFUGEES (Protection and general rights of refugees)
27. A refugee-
(g) is entitled to the same basic health services and basic primary education which the inhabitants
of the Republic receive from time to time.

To avoid contravening patients rights, as precepts to the Constitution (section 27 (3))
and the Refugee Act: Act No. 130 of 1998 (Chapter 5; Section27, (g))

1. Where refugee status have been determined or asylum seekers with or without a permit:

1.1. Basic Health Care:

1.1.1 Refugees / asylum seekers with or without a permit that do access public
health care shall be assessed according to the current MEANS test, (as specified
in the Annexure H).
1.2. **Anti-retroviral treatment (ART)**

1.2.1 Refugees / asylum seekers **with or without a permit** that do access public health care, shall be exempted from paying for ART services irrespective of the site or level of institution where these services are rendered. *(Please refer to the ART directive: BI/429/ART dated the 20th April 2007).*

2. **Full paying patients:**

2.1 The following full-paying patients **are excluded** from free services (basic Health Care and ART) irrespective of the level of care where the service is being rendered:

2.1.1. Refugees / asylum seekers whose income **exceeds** the prevailing means test shall be levied at the full paying UPFS.

2.1.2. Externally funded patients, including members of medical schemes registered in terms of the Medical Schemes Act, 1998 (ACT No. 131 of 1998).

2.1.3. Externally funded patients whose medical schemes **are not recognised** within the RSA scheme pool shall be charged as full paying patients (Self Funded), unless prior arrangements have been made.

2.1.4. Patients treated on account of other state departments, e.g. Compensation Commissioner (COID), SA Police Services, Department of Correctional Services.

2.1.5. Patients treated in state facilities by their **private medical practitioner**.

**NB:** The execution of this directive is with immediate effect.

Your co-operation would be appreciated.

**MR. FG MULLER**  
**CHIEF FINANCIAL OFFICER (CFO) (NDOH)**
Notes:
Urban forced migrants in Johannesburg are found to face specific challenges in accessing public healthcare, including services for mental health and psychosocial support. This report highlights their specific “daily stressors” that are associated with being a forced migrant, including problematic access to documentation; insecure livelihood activities; fear of violence; a lack of trust in the police; poor food security; challenges in accessing healthcare; discrimination by public sector officials; language barriers; inadequate shelter; and, problems in accessing schooling for their children.

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