Migration Issue Brief #8

Towards improving forced migrant access to health and psychosocial rights in urban South Africa

– a focus on Johannesburg

November 2011

The Migration Issue Briefs are a resource for practitioners. They summarise state of the art research and are intended to inform discussions and debates surrounding human mobility in Southern Africa.

Prepared by Jo Vearey, Senior Researcher, ACMS and Lorena Nunez, Senior Researcher, ACMS

Tel: (0)11 717 4041, jo.vearey@wits.ac.za

www.migration.org.za

Introduction

This issue brief is a quick reference guide regarding urban forced migrant access to their legally guaranteed health and psychosocial rights in Johannesburg. We focus on the urban as, in the South African context, forced migrants are mostly found in urban areas. There are no refugee camps in South Africa; the country's refugee policy encourages refugees and asylum seekers to self-settle and integrate. Forced migrants mostly settle in cities and - in some cases - contribute to the growing population of the 'urban poor' found in South African cities, falling within the peripheries of health and social welfare provision by local authorities. An urban health lens is therefore applied to exploring forced migrant access to their legally guaranteed health and psychosocial rights. This involves a consideration of the intra-urban health inequalities associated with cities, particularly in the case of Johannesburg which is acknowledged to be one of the most unequal cities in the world. Urban poor groups experience an "urban health penalty" due to their exposure to unhealthy physical and social conditions (Freudenberg, Galea et al. 2005). Existing research highlights problematic access to public healthcare and other positive determinants of health for all urban poor groups within South Africa, including urban forced migrants. It is within this context that access to the legally guaranteed health and psychosocial rights – including access to public healthcare – of urban forced migrants are explored.

In defining the key concepts applied within this brief, we consider 'forced migrants' to include recognised refugees (holding a section 24 permit) and asylum seekers (holding a section 22 permit), 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 access to secure housing, 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, and to live free of violence and discrimination. We understand the psychosocial as a holistic approach to health, encompassing the social and psychological dimensions of well-being.

Very little research has been undertaken to explore forced migrants' access to psychosocial and mental health services. Some forced migrants experience mental health problems, linked to violence experienced in their country of origin, on their journey to South Africa, and/or within South Africa itself (Bandeira, Higson-Smith et al. 2010). In response to this, a research study was undertaken to explore the psychosocial and health rights of South African citizens and 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 these groups in accessing their health and psychosocial rights, with a focus on their emotional wellbeing. Whilst the findings from this study are not representative of the experiences of all urban forced migrants – and do not capture the experiences of forced migrants who are not currently accessing support - they do provide a useful

indication of the current situation as experienced by forced migrants currently receiving counselling at an inner-city NGO.

Our research shows whilst both South African citizens and forced migrants in Johannesburg experience challenges in accessing public healthcare, including services for mental health and psychosocial support, urban forced migrants experience specific challenges associated with their status as non-nationals. The forced migrants that we interviewed are currently accessing trauma counselling at the CSVR and were referred there by other non-governmental organisations providing support to these groups. These forced migrants are currently part of a parallel health system provided by non-governmental groups that is "filling the gap" and meeting the responsibilities of the public health system. In addition to challenges in accessing public healthcare, the respondents in our survey were found to experience specific "daily stressors" that are associated with institutional blockages and barriers and everyday forms of violence linked to being a forced migrant. "Daily stressors" are demanding social and material conditions that are caused by social marginalisation, a hostile social climate, isolation, inadequate housing and changes in family structure. Existing research demonstrates that "daily stressors" effect psychological well-being (Miller and Rasmussen 2010). The "daily stressors" experienced by urban forced migrants in our study include 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. It is only during their trauma counselling at the CSVR that the role of "daily stressors" in mediating the emotional wellbeing of forced migrants becomes apparent. This results in an increased demand for mental health and psychological support in a context where public access to these services is problematic.

This issue brief 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

Ensuring good health presents many challenges within the complex urban contexts of low and middle-income countries, including: rapid, unplanned urban growth; the migration of people to cities – from both within a country and across borders; inadequate tenure and housing opportunities, resulting in increases in informal urban housing; the context of urban poverty, with expanding numbers of recently urbanised migrant residents adding to the urban poor; higher HIV prevalence than in rural areas; and, increasing intra-urban inequalities that contribute to disparities in the health of developing country urban populations (Dyson 1993; Harpham and Molyneux 2001; UN-HABITAT 2003; Freudenberg, Galea et al. 2005; Garcia-Calleja, Gouws et al. 2006; UNFPA 2007; WHO 2008; WHO 2008; Montgomery 2009). These disparities in health outcomes are experienced by urban poor groups, who tend to be concentrated in unhealthy spaces in the city (for example see Hardoy, Mitlin et al. 2001; Mitlin and Satterthwaite 2004; Vlahov, Gibble et al. 2004; WHO 2005; WHO 2008; WHO 2008).

It is estimated that 6.7% of Johannesburg's total population are cross-border migrants (UNOCHA and FMSP 2009). While rigorous data on the number and location of cross-border migrant populations within urban areas is scarce, a 2002 survey found that almost a quarter of Johannesburg's inner-city residents were born outside South Africa (Leggett, 2003). More recent survey data suggests that in certain inner-city neighbourhoods, over half of the residents are non-nationals(Landau 2006). These findings show that cross-border migrants are concentrated in particular spaces in the city, entering and residing within particular urban areas that are mostly located within the dense central-city. Cross-border migrants enter into an unequal urban environment: South African cities are the most unequal in the world, with an average Gini coefficient of 0.73; Johannesburg (with East London) is shown to have the highest Gini coefficient, of 0.75 (UN-HABITAT 2008). This makes Johannesburg one of the most unequal cities globally.

Unlike other countries in the region, no refugee camps exist in South Africa and many refugees and asylum seekers find themselves in complex urban environments such as Johannesburg. These individuals are assured a range of rights, including those to protect their health and psychosocial wellbeing. However, these rights are not always upheld. The South African Constitution and the Refugee Act afford forced migrants a range of rights, including those to protect their health and psychosocial well-being. Refugees and asylum seekers within South African cities are expected to become self-sufficient by earning a living and integrating within the host community. 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 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.

Our research findings support existing evidence that mental ill-health is strongly associated with poverty and the social deprivation associated with poverty (Nunez 2009; Burns 2011). The context of urban inequality that is associated with Johannesburg clearly affects residents – both South African and forced migrants. As a result, some "daily stressors" are found to be experienced by South African citizens who are also reliant on public healthcare, whilst others are unique to urban forced migrants. 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 and xenophobia. These "daily stressors" negatively affect their emotional wellbeing, adding to any pre-existing trauma or emotional distress; stressors may become additional or secondary traumatic experiences. Findings indicate that the negative impact of "daily stressors" on emotional wellbeing presents a barrier to improvement in mental health conditions associated with pre-existing trauma. This results in an increased demand for mental health and psychological support in a context where access to public services is problematic – due to (1) discrimination experienced in the public sector and (2) a lack of public sector mental health services.

The Relevant Policy Context

Migration and health

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, and 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 2007). 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 Preston-Whyte 2006; Vearey 2008; IOM 2010; Moyo 2010; CoRMSA 2011; Vearey 2011). South Africa ratified Resolution 61.7 of the 61st annual World Health Assembly (WHA) on the Health of Migrants, which calls on member states to promote equitable access to health promotion, disease prevention and care for migrants (World Health Assembly 2008).

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 a 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 higher-level 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 and mental health services. The current Green Paper suggests that the rights of non-nationals to access free care will be removed.

Mental health

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.

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 (Lund and et al. 2010; Burns 2011). As a result, public mental healthcare services remain inadequate. For example, South Africa has only one third of the number of psychiatrists set by international norms, and only 28% of people with moderate – severe common mental disorders receive mental healthcare (Burns 2011).

Key findings

The living conditions of forced migrants in Johannesburg are challenging, leading to multiple "daily stressors" that result 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 expressed that they are unwilling to put themselves into situations where they are laughed at and feel discriminated against. As a result, it is very difficult for forced migrations to access medication and care consistently and efficiently within the public sector. Both South Africans and forced migrants have negative experiences of accessing health care especially in public health care institutions. This highlights the 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.

National, provincial and local government departments should be involved in promoting the well-being of urban residents, including forced migrants. The promotion of well-being includes the promotion of justice in responding to the basic needs of residents. 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).

Counselling alone will not successfully address the mental health challenges of urban 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. An integrated response that addresses the legislated psychosocial rights of forced migrants is required.

Recommendations

Recommendations to national, provincial and local government

- Improve responses to urbanisation, migration and urban health. This includes developing capacity within the multiple spheres of government to engage with these issues and develop appropriate responses.
- Strengthen the distribution, awareness, implementation and monitoring of existing protective legislation relating to the rights of forced migrants.

Specific recommendations to the National Department of Health

- Take action on urban health and position urban health and migration and position these as critical dimensions of South Africa's public health response.
- Re-visit the Mental Healthcare Act and work towards its implementation.
- Strengthen the distribution, awareness, implementation and monitoring of existing protective legislation relating to the health and psychosocial rights of forced migrants.
- 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.
- Provincial and metro health departments should 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.
- 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. Frontline staff, medical personnel and management should all participate in these change and action-oriented trainings.
- Adapt existing training and support resources. 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 the incorporate a specific session on psychosocial rights, and the mental health needs of forced migrants, and delivered at facility, metro and provincial levels.
- Ensure the rights of refugees and asylum seekers to access public healthcare are upheld within the National Health Insurance plan.

- Improve the referral system between non-governmental organisations that provide services to forced migrants and the public healthcare system.
- Incorporate translators and cultural brokers into public health services provided to forced migrants.
- Strengthen the screening for mental health problems at primary healthcare clinics and the upward referral for treatment within the public healthcare system.
- Healthcare institutions should create channels of communication and establish dialogue with community based organisations - including organisations representing forced migrants - to understand their health needs, and to establish ways to collaborate and work together towards creating healthy communities.

Specific recommendations to civil society

- Promote local / community organizations to provide voice and support to the concerns of forced migrants.
- Support initiatives that strengthen human rights, and as part of this the psychosocial and health rights of forced migrants.
- Explore the coping mechanisms that forced migrants engage with in order to face their daily stressors; recognize and support their alternative healing strategies.
- Advocate for the specific mental health needs of forced migrants to be considered in public health system responses.
- Engage with clinics and district health systems in order to establish opportunities for dialogue with healthcare providers on issues relating to the mental health needs of forced migrants.

References

Bandeira, M., C. Higson-Smith, et al. (2010). "The land of milk and honey. A picture of refugee torture survivors presenting for treatment in a South African trauma centre." TORTURE**20**(2): 92 - 103.

Burns, J. (2011). "The mental health gap in South Africa - a human rights issue." The Equal Rights Review**6**: 99 - 113.

CoRMSA (2011). Protecting Refugees, Asylum Seekers and Immigrants in South Africa. Johannesburg, CoRMSA.

Dyson, T. (1993). "HIV/AIDS and Urbanization." Population and Development Review**29**(3): 427 - 442.

Freudenberg, N., S. Galea, et al. (2005). "Beyond urban penalty and urban sprawl: back to living conditions as the focus of urban health." J Community Health**30**(1): 1-11.

Garcia-Calleja, J., E. Gouws, et al. (2006). "National population based HIV prevalence surveys in sub-Saharan Africa: results and implications for HIV and AIDS estimates." Sex Transm Infect**82**(Supl III): iii64 - iii70.

Hardoy, J. E., D. Mitlin, et al. (2001). Environmental Problems in an Urbanising World. London, Earthscan.

Harpham, T. and C. Molyneux (2001). "Urban health in developing countries: a review." Progress in Development Studies**1**(2): 113-137.

IOM (2010). Migration and Health in South Africa: A Review of the Current Situation and Recommendations for Achieving the World Health Assembly Resolution on the Health of Migrants. Pretoria, International Organization for Migration.

Landau, L. (2006). "Protection and Dignity in Johannesburg: Shortcomings of South Africa's Urban Refugee Policy." Journal of Refugee Studies**19**(3): 308.

Lund, C. and et al. (2010). "Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications." Soc Psychiat Epidemiol**45**: 393 - 404.

Miller, K. and A. Rasmussen (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.

Mitlin, D. and D. Satterthwaite, Eds. (2004). Empowering squatter citizen: local government, civil society and urban poverty reduction. London, Earthscan.

Montgomery, M. (2009). Urban poverty and health in developing countries, Population Reference Bureau. **64**.

Moyo, K. (2010). Street level bureaucracy: the interface between health personnel and migrant patients at Hillbrow Community Health Centre. Unpublished MA Thesis. Forced Migration Studies Programme, University of the Witwatersrand.

NDOH (2007). Revenue Directive - Refugees/Asylum Seekers with or without a permit. BI 4/29 REFUG/ASYL 8 2007. Department of Health. Pretoria.

Nunez, L. (2009). "Is it possible to eradicate poverty without attending to mental Health? Listening to migrants workers in Chile through their idioms of distress." Journal of Health Management**11**(3): 337 - 354.

Preston-Whyte, E., Tollman, S., Landau, L. and Findley, S. (2006). African Migration in the Twenty-First Century: Conclusion. Africa on the Move: African Migration and Urbanisation in Comparative Perspective (pp.329-355). F. M. Tienda, S., Tollman, S. and Preston-Whyte, E. (Ed.). Johannesburg, Wits University Press.

The Republic of South Africa (1996). The Constitution of the Republic of South Africa - No. 108 of 1996, Pretoria.

The Republic of South Africa (1998). Refugee Act - Act No. 130, Pretoria.

UN-HABITAT (2003). The Challenge of Slums — Global Report on Human Settlements 2003, UN-HABITAT.

UN-HABITAT (2008). State of the World's Cities 2008/2009: Harmonious Cities. London, Earthscan.

UNFPA (2007). State of the World Population 2007. Unleashing the Potential of Urban Growth. New York, United Nations Population Fund.

UNOCHA and FMSP (2009). Distribution of Migrants in South Africa by District Municipality from 2001 to 2007. Pretoria, UNOCHA.

Vearey, J. (2008). "Migration, access to ART and survivalist livelihood strategies in Johannesburg." African Journal of AIDS Research**7**(3): 361 - 374.

Vearey, J. (2011). "Learning from HIV: Exploring migration and health in South Africa." Global Public Health**DOI: 10.1080/17441692.2010.549494**.

Vlahov, D., E. Gibble, et al. (2004). "Cities and health: history, approaches, and key questions." Acad Med**79**(12): 1133-1138.

WHO (2005). A Billion Voices: Listening and responding to the health needs of slum dwellers and informal settlers in new urban settings. Healthier peoples in healthier environments, WHO Kobe.

WHO (2008). Closing the gap in a generation. Health equity through action on the social determinants of health. Geneva, Commission on Social Determinants of Health.

WHO (2008). Our cities, our health, our future. Acting on social determinants for health equity in urban settings. Geneva, Commission on the Social Determinants of Health.

World Health Assembly (2008). Resolution 61.17 'Health of Migrants' A61/VR/8 Sixty-first World Health Assembly. Geneva, WHA.

Selected ACMS Publications on Health and Migration

- Núñez, L., Vearey, J. and Drimie, S. (2011) Who cares? The impact of HIV-related sickness on migration patterns in South Africa *Gender and Development***19** (1) 105 – 114

- Vearey, J. (2011) Challenging urban health: towards an improved local government response to migration, informal settlements and HIV in Johannesburg, South Africa *Global Health Action***4**: 5898 - DOI: 10.3402/gha.v4i0.5898

- Vearey, J. (2011) Learning from HIV: exploring migration and health in South Africa *Global Public Health* DOI: 10.1080/17441692.2010.549494

- Núñez, L., Vearey, J. and Drimie, S. (2011) Who cares? The impact of HIV-related sickness on migration patterns in South Africa *Gender and Development* **19** (1) 105 - 114

- Vearey, J. (2010) Migration and Health Delivery Systems in Southern Africa *OPENSPACE (Journal of the Open Society Initiative for Southern Africa)***3** (3)

- Vearey, J. (2008) Migration, access to ART and survivalist livelihood strategies in Johannesburg *African Journal of AIDS Research***7**(3) 361 – 374

ACMS Contact People on Health and Migration

- Jo Vearey, Senior Researcher, jo.vearey@wits.ac.za, (0)11 717 4041
- Lorena Núñez, Senior Researcher, lorena.nunezcarrasco@wits.ac.za, (0)11 717 4084
- Matthew Wilhelm-Solomon, Post-doctoral Research Fellow, matthew@migration.org.za

For further information see http://migration.org.za

or contact us on 011 717 4696, info@migration.org.za

ACMS, University of the Witwatersrand, PO Box 76, WITS 2050, South Africa