Towards Improving Forced Migrants' Access to Health and Psychosocial Rights in Urban South Africa

Meeting report: Policy Dialogue
30th November 2011
University of the Witwatersrand

co-hosted by the African Centre for Migration & Society, Wits and the Centre for the Study of Violence and Reconciliation

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List of Acronyms

ACMS	African Centre for Migration and Society
AMIS	African Migrants Solidarity
CSVR	Centre for the Study of Violence and Reconciliation
DHSD	Department of Health and Social Development
DHA	Department of Home Affairs
DOH	Department of Health
DSD	Department of Social Development
IOM	International Organization for Migration
MSF	Medecins Sans Frontiers
RAO	Refugee Aid Organisation
RNA	Refugee Nurses Association
UNAIDS	United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner For Refugees

Overview

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 and the Refugee Act, 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. 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.

Building on the 2010 National Consultation on Migration and Health in South Africa that discussed operationalizing the World Health Assembly (WHA) Resolution on the Health of Migrants[1], a policy dialogue was held in November 2011 to discuss the psychosocial and health rights of forced migrants. A recent report by the ACMS and CSVR highlights the challenges that forced migrants face in accessing their health and psychosocial rights in Johannesburg. This policy dialogue was created to discuss the findings, implications and to map a way forward.

[1] IOM and ACMS, 2010. Migration and Health in South Africa: A review of the current situation and recommendations for achieving the World Health Resolution on the Health of Migrants. The report includes the WHA Resolution. Available online: http://tinyurl.com/ckl75xf

Introduction

The policy dialogue "Towards improving forced migrants access to health and psychosocial rights in urban South Africa" took place on the 30th of November 2011. It was well attended, with 47 members of migrant communities, government, civil society and academia coming together, providing a rare opportunity for a variety of stakeholders to directly engage with each other openly and freely. The dialogue was chaired by Nomfundo Mogapi (CSVR) who mentioned in her introductory remarks the importance of involving migrants themselves in these discussions rather than only having civil society speak "on their behalf". She explained that the policy dialogue formed the final step of a project that the ACMS had been conducting in collaboration with CSVR on access to psychosocial and health services The motivation for this dialogue was for all stakeholders to engage with the findings of the research as well as commit to practical, specific future steps to be taken for all organisations and stakeholders involved.

The dialogue was opened with a performance by both migrant and South African women from the Rosettenville community. The piece enacted various situations where patients are turned away from a clinic due to lack of language skills or documentation or are wrongly advised and laughed at. It also highlighted the issue of staff shortages, inefficiency and bad management of queues at local clinics. The final scene showed how the women wished they would be treated when they seek health care – with friendliness ("a smile does a lot") and understanding, competent and welcoming staff.

I: Inputs by civil society organisations working in the field of health and migration

Following the performance, several organisations gave presentations on the work they are doing and the challenges they face. The first presentation was given by Dr. Jo Vearey from the African Centre for Migration and Society (ACMS).

Vearey explained that mental health is a global crisis, with an estimated 9 out of 10 people in developing countries unable to access adequate services. She explained that migration is a global reality, with around 3 per cent of the world's population being categorized as international migrants. In this sense, South Africa with an estimated 3.7 per cent of foreign born population is simply reflecting a global trend. However, there are great differences between different South African cities as well as within them. The amount of foreign born residents in Johannesburg is just under 7 percent, so much higher than the national average. However, particular suburbs within Johannesburg differ vastly. While the population of some suburbs in Johannesburg is largely composed of foreign and/or internal migrants, it is important to remember that this is not necessarily the case in other parts of the city. Vearey thus emphasized the importance of local context, i.e. that "migration means different things in different places." She highlighted that it is not an easy task to find an appropriate national response given these vast differences, and that cities often struggle with the mobility of their residents, use outdated data and allocate funds in a way that does not match the actual population dynamics on the ground. She also explained that Johannesburg is an extremely unequal city, with a GINI coefficient of 0.75.[2] This inequality presents a problem, because it is difficult to advocate for the rights of migrants when there is a huge group of citizens that are already experiencing huge challenges.

[2] 0 equals total equality, 1 equals total inequality

She explained that it is important to acknowledge that when people cannot access treatment for communicable diseases such as HIV and TB, this does not only infringe on the legislated rights and wellbeing of an individual person but creates marginalised groups. According to Vearey, evidence also shows that mental health has an impact on development and poverty, and as such is as concern that goes far beyond the health sector.

Vearey emphasized that there is a wealth of data available now that has been collected over the last 15 years. The existing research documents the problems and suggests ways forward to address the weaknesses and obstacles in the current system. However, what is now needed are partnerships between NGO's government and communities to translate these findings into action and work together to design successful interventions. She explained that it was not about the NGO sector creating a parallel health care system, but about NGOs and government working together to be able to address health at the population level.

She emphasized that while migrants are often accused of bringing diseases such as TB and HIV/AIDS, there is no empirical evidence to support this claim. There is also no evidence that - apart from a few isolated cases - individuals move to South Africa specifically to access health care. In fact, on arrival, migrants tend to be healthier than their hosts. However, there is evidence that the conditions under which people move, and the places that they find themselves in, make them more vulnerable to ill health, and quickly. This applies to foreign as well as internal migrants alike.

The conditions under which people move, and the places that they find themselves in, make them more vulnerable to ill health.

Living in Johannesburg brings about a new set of stresses that makes people vulnerable to ill health, including psychosocial health. This was documented in the joint study between CSVR and ACMS on *"Exploring the Psychosocial and Health Rights of Forced Migrants in Johannesburg: The impact of 'daily stressors' on the emotional wellbeing of forced migrants"*. Vearey explained that the number of participants interviewed this study was not very high but allowed for an in-depth understanding of forced migrants' experiences with mental health problems, access to services and the stress of living in Johannesburg. However, she emphasised that this group of study respondents is not representative as they are already accessing services, which differentiates them already from the many that do not. She explained the concept of "daily stressors", which describe the various challenges migrants in Johannesburg face (such hunger, struggling to provide for one's family, finding secure shelter, constant fear of police and deportation, social marginalisation) which are proven to have a big impact on mental health. These daily stressors usually have little to do with previous trauma, but instead are "added onto it". Vearey highlighted that accessing the health care system in itself is a stressor, as worrying about the problems that migrants are likely to encounter as well as their experiences in the clinics increase anxiety. The fear of deportation since the lifting of the moratorium also adds a whole new layer of stress that needs to be acknowledged. She explained that being ridiculed and laughed at due to a lack of language skills at a clinic makes you feel disempowered, which will have an effect on your ability to cope if you already suffer from anxiety or depression. According to her, all of these obstacles in the health care system can be easily addressed, and thus reduce an important source of stress for migrants.

Johanna Kirstner presented on the work of Sophiatown Community Psychological Services (SCPS) in Bertrams. Her organization tries to help people under very difficult circumstances by recreating safe spaces for emotional refuelling, the creation of new social networks and restoring people's courage and

resilience. Their clients included adults, adolescents and children. She explained that 80 per cent of their clients are female, and that another 80 per cent of the women that come are single and often abandoned by their husbands. Most of the clients come from the DRC but also from Zimbabwe, Burundi, South Africa and other countries. She spoke about how working in the inner city pushes the counsellors out of their "therapeutic comfort zone", as they work with extremely vulnerable and marginalised population. These refugee populations do not only have discrete episodes or events of trauma to deal with, but instead are located within an on-going "landscape of suffering" in a very hostile and challenging environment. She explained that it was often difficult to deal with the traumas that forced migrants experienced prior or during their move, because the "daily stressors" of Johannesburg were overshadowing everything prior. She referred to "hunger-anger" as one of these stressors, where clients are so angry at constantly being hungry that therapy and relationships with clients are often difficult to manage.

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Kirstner explained that many women suffer from a "broken link between past and current identities", for example, if a woman's identity was based on being a mother and wife, her identity was displaced when she arrived in Johannesburg, abandoned by her husband, having to provide for her children in a foreign country whose language she does not understand. Oftentimes, the children integrate much quicker and are the breadwinners. This changes relationships within the family and often gives children "inappropriate powers" over their parent. Kirstner also spoke about the fact that when clients arrive at her organisation, they have often told their stories many times (for example at immigration, the DHA, the DSD), so stories are often "costume-made for survival" which is difficult to deal with as a therapist.

According to Kirstner, the goal is to move women away from a "refugee identity" as soon as possible and to restore their sense of self-hood and inviduality. She explained that a lot of the psychosocial support was achieved through group work, often with refugee women who had gone through similar traumas and experiences. Afterwards, women often join mixed groups with South Africans in order to build new solidarities, learn about similar challenges and to absorb some of the human rights language of protection that South African women are more familiar with. Individual sessions were reserved for dealing with daily stressors. In some desperate cases, her organization provided material support, but only under the condition that clients were actively engaged in a healing process – and as such, giving material support was a clinical decision, not a humanitarian decision.

Jens Pederson from MSF described his organisation as a medical humanitarian organisation with medical assistance as their core mandate. He spoke about several successful collaborations of MSF with government, for example in the aftermath of the xenophobic violence in 2008, where MSF provided mobile health care in the temporary shelters for displaced migrants, or in 2009 where MSF provided assistance when cholera broke out amongst the Zimbabwean population. He also spoke about an Antiretroviral (ARV) programme that MSF managed in the Cape, where more than 20.000 people had been provided with medication, a model which has been offered as a model to the department of health. Pedersen explained that the DOH shared epidemiological data with MSF during the cholera crisis when MSF treated patients in inner city buildings and the Central Methodist Church.

Currently, MSF is very engaged in outreach activities and networking exercises within inner city buildings in order to help prevent and limit the spread of communicable diseases. He spoke about the fact that the conditions in many buildings are very bad and that MSF assisted residents in cleaning the buildings and removing waste. Buildings are often rat-infested, people live in overcrowded conditions, lack of sanitation, and these spaces constitute a huge public health threat. MSF works in 40 buildings at the moment. He explained that MSF have worked on accessing the population, whereas the DOH waits for populations to access them. MSF also supports two government clinics with HR, nursing and counselling staff to share the huge task that government is dealing with. According to Pedersen, MSF's presence in the clinics not only increases trust of patients previously acquainted with MSF's work, but also provided MSF with "a finger on the pulse" of what is happening with migrants access to health.

Pedersen spoke about the challenges for an organisation like MSF that is used to work in quite structured environments such as refugee camps, and in Johannesburg has to work in very complex, fluid contexts of urbanisation and migration. However, MSF is trying to adapt and to develop models of care for mobile populations, especially for chronic conditions such as HIV, TB, hypertension etc. which are very difficult to manage as people are on the move and records and treatment regimes only known at one clinic.

We are working on accessing the population, whereas the Department of Health waits for populations to access them.

He stated that although there are sometimes conflicting priorities, the shared emphasis on public health makes it easy for MSF to partner with the DOH. He argued that for mental health issue it would be a bit more difficult to find common ground with government would - although it has wider implications on development - but that the public health approach is easier to highlight in relation to somatic diseases.

II: Inputs by members of migrant communities

Patricia Mabunda from the Mayfair Women's group explained that South African women and migrant women share many challenges. However, with regard to migrants in particular, she said that at her local clinic, the protective policy is not being translated into protective practice, regardless of the rights enshrined in the constitution and the the refugee act of 1995. She highlighted issues of incompetent and ill-trained staff, staff shortages, long waiting times for patients, and bad communication between patients and health care provides about the nature of the diagnosis and treatment. She urged the department of health to improve the system and respect migrants in order to achieve better health care for all.

Protective policy is not being translated into protective practice

Dr. Walter Mulumba from the Rosettenville community spoke about the anxiety a visit to the clinic caused for many migrants already days before they went, and the problems of providing a correct diagnosis when patient and doctor are unable to communicate with each other properly. He said that as foreigners, you are unlikely to be attended to appropriately, and most often just sent away with insufficient medication such as Panado rather than a proper treatment. He also explained that expensive exams made it very difficult for foreign doctors to work in South Africa. He urged government employ health care providers from the SADC region to be able to ensure sufficient communication and

understanding between patients and doctors. He also emphasised that nurses and receptionists need to be better trained about the rights of all people regardless of race and origin.

III: Presentations by government departments working in the field of health and migration

Wandile Zwane from the city of Jo'burg spoke about the city's Growth and Development Strategy (GDS) which considered all residents of Johannesburg important players that need to be involved. He stated that it is an important task to translate policy into protective practice. He explained that from his experience the stresses of migrants were universal and that even in developed countries there are challenges. The Jo'burg GDS affirms the city's commitment to access to services for all, and that policy dialogues such as this one contribute to this call.

"Jo'burg's Growth and Development Strategy affirms the city's commitment to access to services for all."

The goal for the city is to become a vibrant, dynamic and caring place. He stated that "integration and inclusivity are nice things, but a difficult thing to implement." He explained that in March of 2012, many of such input of civil society will be incorporated into the future vision of the city. He said that the city is aware of the issues of migration, urbanization and its implications for health and housing. He raised six points that he sees as vital for the discussion. Firstly, while the constitution enshrines the state's obligation to provide health care for all, for many migrants that experience is not real, and something needs to be done about that. Secondly, the failure to secure migrants' access to health care has short term immediate impacts for the individual and his or her dependants, but also pose a threat to public health as communicable diseases do not discriminate between migrants and citizens. Thirdly, the task of ensuring access to health care for everyone is a shared responsibility for national, provincial and local government. Fourthly, there is a lack of understanding about the fact that the health status of migrants impacts on everyone around them, as we use the same streets, the same buses, and as such we need to use the same health care. Fifthly, health care workers need to be trained in order to be able to work across cultural barriers. Finally, services need to be provided to all migrants in the city of Johannesburg,

"The failure to secure migrants' access to health care has short term immediate impacts for the individual and his or her dependants, but also poses a threat to public health as communicable diseases do not discriminate between migrants and citizens"

He highlighted the successes of existing partnerships, for example of that between the Population Council and the City of Johannesburg. He also stated that migrants are too often viewed as passive agents who are often subject of research, but that if we are to counter negative perceptions about migrants we need to modify the role of migrants to become active participants in debates on inclusion and integration. He stated that the city of Jo'burg has placed its future firmly within a collaborative approach, of which this kind of dialogue is part of. He also spoke about an integration policy for migrants in Johannesburg, which will make the city the first of its kind in South Africa to have a reception strategy. As part of this, the city emphasized the importance of language and establishment of centres that teach newcomers some of the South African languages, as well as increase participation of migrants

in the structures o the city. The migrant help desk was there to provide information to migrants about how the city operates, but also what the city expects of migrants.

Dr. Chika Asomugha, Acting director of Public Health at the provincial Department of Health and Social Development (DHSD) presented on Gauteng's approach to public health. He emphasised that the DHSD is guided by the principles of the SA constitution and the bill of rights, which enshrine the rights of everyone regardless of citizenship status or nationality. Asomugha stated that the DHSD's vision is "to be the best provider of quality health and social services to the people in Gauteng", in partnership with organisations like MSF and World Vision. He explained that the DHSD's priorities are communicable diseases such as HIV but also Malaria and lifestyle diseases. He stated that health care services should be comprehensive, deficient, effective, equitable, affordable and accessible to all. He emphasised that the onus is on victimized people to report abuse and discrimination.

Myrtle Morris from the Gauteng Health and Social Development presented on the areas of Social Welfare Services and Specialised Social Services that her department are engaged in, and emphasised that migrants have and should have the same access to services as South Africans. Morris explained that her department concentrates on protecting vulnerable groups such as women, children, people with disability, the elderly, single/child/granny headed households, households affected by HIV/AIDS, youth in conflict with the law, and those who abuse substances. She explained that the DHSD had recently collaborated with IOM in a training of DHSD staff on migrant rights.

IV Questions and Answers with Dr. Chica Asomugha (Acting director of Public Health at the provincial Department of Health and Social Development)

Q: At the moment, everyone has at least on paper the right to access health service, but from a reading of the green paper on the system of a NHS in South Africa it seems that this right will only be afforded to citizens and permanent residents in the future. Is that true?

A: No, it will be accessible to foreigners, because anything else would be discrimination and against the bill of rights.

Q: How are the regulations and implementation of policy going to be monitored? How are you going to ensure that the rights of migrants are respected in all sectors?

A: Every system needs evaluation from time to time. That is why we have a monitoring and evaluation unit that collects grievances, aggregates this information and takes it to the political head of the department. For example, in the Hillbrow clinic there have been complains that nurses have been arrogant towards Zimbabwean migrants and people were sent to address this problem immediately. There should be no discrimination. If you have a complaint, do yourself and the government a big favour and report your complaint.

Q: How do you ensure that government employees follow the official regulations? Decisions makers like you should come to the field to get a first-hand experience of what is going on. When I phoned the quality assurance hotline, I had to wait for over 40 minutes in the line before talking to someone.

A: Some of us go into the fields into hospitals, and we pretend to be patients ourselves. But what I discovered is that this attitude is not peculiar to foreigners, it is almost the same with South Africans, so it is more an attitude towards service delivery and of course we try to catch those who do not follow our policies. But anyone here who feels they have not been treated well because they are a foreigner can phone me on my personal number 076 890 3429 or 082 330 1490. Otherwise, you can phone Zodwa Kumee who is the head of quality. My advice is that you can also always escalate your complaint to the Zuma hotline [toll-free number, 17737]. *I also want to encourage for people to give their correct addresses and phone numbers when they come to our clinics, we are not immigration, we just need to be able to reach you to follow up.*

A doctor working in an Ekuhurleni hospital advised the group that every hospital has a quality assurance officer, a clinical manager and a chief executive officer that should be approached before escalating the complaint to Dr. Asomugha.

Q: Why don't you roll out a big campaign with posters and pamphlets in different languages to inform people about their rights?

A: We can only concentrate on the major languages, which are English, French, Portuguese and Swahili. We cannot do this in all the hundreds of languages; we cannot even do this in all the South African official languages.

V. Recurrent Themes

Throughout the discussions between all participants, the following key themes recurred frequently:

- The impact of "daily stressors" on migrants' mental and physical health
- The challenges that migrants faced in accessing services due to lack of language skills and discrimination
- The similarities between South Africans and migrants, as both groups were affected by issues like undertrained staff and bad queue management
- The need for mainstreaming migration into the health care system and to strategically approach the rights of migrants within a public health approach. It was often mentioned that while there are some more migrant-specific language, we should be careful of "exceptionalising" the experiences of migrants. A migration lens on the health care system will eventually remove obstacles and challenges of access for the entire population in South Africa. It was highlighted that the current period where the NHI is being drafted provides a great opportunity to mainstream migrant rights into the new policies and operational plans.
- The gap between policy, constitutional rights, legislation and implementation
- The importance for migrants themselves to be proactive, integrate into South African society and be aware of their rights as well as their obligations.
- The need for health care providers to receive training and information about the legislated rights of migrants
- The importance of integrating refugee nurses and doctors as well as interpreters into the health care system to solve many of the communication issues.

- The high level of mistrust that foreign migrants have in the health care system, not only because of experiences with bad treatment and discrimination but also for fear of deportation and immigration policing.
- The fact that migrants without documentation have much more challenges in accessing services than those who do.

VI. Results of Group Discussions

In the final part of the policy dialogue, participants were divided into four working groups in order to answer questions about current responses, what needs to be done, how it should it be done, and who should be coordinating it. Participants were also asked to make specific commitments on behalf of their organisations.

Group 1: Mental Health

Current responses:

- Responsibility for access to mental health currently rests mainly on civil society.
- Access to mental health for refugees is possible through the SASA grant, but only for refugees who have their maroon ID book. This is problematic given that it often takes over a year or even litigation (instead of the legislated 3-6 months) to receive official documentation for refugees.
- Food banks are important so refugees can take their medication
- Refugees often find it difficult to access shelters and families are often split up which exacerbates mental health issues.
- Access to mental health services appears to be easier in Pretoria than in Johannesburg.

What is needed:

- Language centres will ideally alleviate the language barriers for clients seeking services
- There needs to be a link between city and provincial level with regard to shelter through the "shelter forum"
- There need to be shelters where entire families can be placed.
- It would be good to have a contact person with the department of health to talk to directly
- Utilise the forced migration working group and the JMAP
- The Refugee Aid Organization will attend health forum meetings and take the information to the Forced migration working group, CSVR will take information from JMAP to the forced migration working group.
- A monthly task team meeting will be established.

Group 2: Public Health

Current responses:

- Current responses and policies in South Africa are very good because they give equal rights to citizens and foreign migrants. However the problem is implementation.
- There are existing partnerships between civil society and government.

What is needed:

- Sensitization and training on migrant rights and different legal statuses of migrants. This training needs to be conducted in a continuous and not just a once-off manner.
- Service providers and migrant communities need to be informed about how the health system works. Migrants need to know about their rights and obligations.
- There is a need to communicate policies to both implementers and the general public.
- Healthcare in general needs to be improved all over the country.
- There needs to be training for health care providers on migrant issues .
- There needs to be more information to the public and migrant communities via radio shows or pamphlets. These campaigns need to be conducted in the languages that migrants understand.
- Everyone (NGOs, CBO's, FBO's, government and communities) need to be involved in these tasks. It is not a task that any stakeholder can tackle singularly
- The RNA and AMIS will conduct translation projects in clinics
- RAO is mobilising to teach clients their rights
- CSVR is engaging with communities and disseminates information to other NGOs
- CormsA is accessing policy makers
- UNHCR supports smaller organisations who work with and for migrants
- Section 22 (law clinic) works towards ensuring that policies are implemented and migrant rights are protected
- Nazareth House (HIV clinic) is networking with the government

Group 3: Alternative health care and healing strategies

Current responses:

- Spiritual groups, traditional healers, NGOs, support groups
- People often abuse alcohol or engage in risky sexual behaviour as a coping mechanism when their needs for help and healing are not met otherwise
- Responses are often not culturally sensitive. There is a need to mediate the cultural differences within the community
- The role of the family needs to be reinforced

What needs to be done:

- Elders, spiritual and local leaders should be approached that allow the entrance into the community
- Campaigns need to be culturally sensitive and respond more to the needs of particular communities. Communities should be involved in the design of campaigns.
- Research needs to be conducted as it provides an important tool for lobbying

Group 4: Access to documentation

Current responses:

- The refugee act provides good legislation but it is currently not implemented
- DHA has no capacity of DHA to detect mental health issues.
- Access to services is difficult for migrants within detention and deportation centres.

What needs to be done:

- Officials within the three key departments of DOH, DHA and DSD need to be trained on migrant rights.
- Other service providers or agencies need to come into the picture and try to approach the DHA, in particular the immigration unit, about the bad services in these centres.
- The head of immigration services at the DHA needs to be approached about access in deportation centres.
- On the issue of capacity of health officials, IOM has an existing training that is being piloted. This programme can be adopted and adapted by different agencies. IOM can take the lead on capacity building.

VII. A way forward

The policy dialogue signalled another constructive step in the process towards improving access to legislated health rights for cross-border migrants in South Africa. Building on the 2010 National Consultation, the meeting provided an opportunity to take stock of where progress is being made, and to highlight what still needs to be done. The active participation of national government and the City of Johannesburg within the discussions is recognised. As we move forward to realising the legislated health rights of cross-border migrants in South Africa, it is hoped that the dialogue will continue. It is essential that the multiple stakeholders continue to advocate and take action for change.

The Johannesburg Migrant Health Forum (MHF) meets every second month at the Hugh Solomon Building, Esselen Street, Hillbrow. The first meeting of 2012 will take place on Wednesday 18th January, 11am – 1pm. Please contact Pascal Minani for further information: pminani@wrhi.ac.za