Challenges to the successful implementation of policy to protect the right of access to health for all in South Africa

Report to Dr Patrick Maduna
Chief of Services: Gauteng Department of Health

3 June 2008

Nazareth House ART Clinic

University of the Witwatersrand
Forced Migration Studies Programme

University of the Witwatersrand
Steve Biko Centre for Bioethics

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Prepared by Jo Vearey and Marlise Richter on behalf of the Migrant Health Forum

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Background Note to the report

On the 14th May 2008, Dr Patrick Maduna met with representatives of the Department of Family Medicine and the Steve Biko Centre for Bioethics to discuss the on-going problems that foreign migrants have in accessing health care in Gauteng. Dr Maduna requested a report which summarized evidence and experiences of organizations and individuals who work with migrant populations.

This report has been endorsed by the following entities:

- AIDS Consortium
- Consortium for Refugees and Migrants in South Africa (CoRMSA)
- Family Medicine (Wits University)
- Forced Migration Studies Programme (Wits University)
- Lawyers for Human Rights (LHR)
- Nazareth House
- Reproductive Health and HIV Research Unit (RHRU)
- Steve Biko Centre for Bioethics (Wits University)
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Executive Summary

The recent brutal xenophobic attacks in Gauteng have highlighted tensions between South African citizens and foreign migrants. Whilst migration into South Africa is by no means a new phenomenon, increasing civil conflict and economic hardship experienced across the African continent, and beyond, have resulted in an increased number of foreign migrants making South Africa their (temporary) home. While a substantial number of migrants bring valuable skills and entrepreneurial expertise into South Africa, many are left destitute as a result of conditions in their home countries and the challenging bureaucratic, and now increasingly violent, environment in which they find themselves.

Migrants have a constitutional right of access to basic services. South Africa has an integrative urban refugee policy whereby refugees and those seeking asylum are encouraged to self-settle and integrate. Whilst this is a progressive policy and protective legal framework, many challenges exist to effective implementation; of particular concern is access to documentation and to healthcare services.

This report will specifically highlight the challenges that foreign migrants – including refugees and asylum seekers – face when trying to access public health services in South Africa. This report draws on the experiences of a range of non-governmental organisations, research institutions working “on the ground” with migrant groups and individuals. The report consists of documents compiled by member organisations of the Migrant Health Monitoring Forum.

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1 Section 27 of the South African Constitution applies to “everyone” and reads as follows:

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

2 The Refugee Act (1998)

3 See for example: (Jacobsen, 2006; Landau, 2006)

4 See for example: (CoRMSA, 2007; Pursell, 2006)

5 Lawyers for Human Rights (LHR), Wits University: Forced Migration Studies Programme, Wits University: Family, Medicine, Wits University: Steve Biko Centre for Bioethics, Reproductive Health and HIV Research Unit (RHRU), Consortium for Refugees and Migrants in South Africa (CoRMSA) and Nazareth House ART Clinic.
This Forum brings together practitioners, researchers, CBOs, NGOs, IGOs and advocacy groups who are involved in ensuring that the right of access to health is achieved for all migrants in South Africa, including refugees, asylum seekers and undocumented migrants. The aim of the Forum is to monitor and act upon challenges that migrants face in trying to access public health services within South Africa, and to work towards improving this.

The Forum forms part of a national civil society movement toward safeguarding and ensuring the effective implementation of migrant rights generally, and access to healthcare specifically.

The Forum commends the clear directives and memoranda issued by both national and Gauteng Provincial health departments that clarify that:

- Everyone within South Africa’s borders is entitled to receive basic healthcare services, including emergency care;
- South African green bar-coded identity booklets are NOT a pre-requisite for basic healthcare or ART services; and
- All refugees and asylum seekers – with or without a permit – are entitled to basic healthcare and the same means test for South African citizens must be applied, not foreign patient rates.

**Key findings**

However, the Forum wishes to highlight the following key points, showing that the principles outlined above are not effectively implemented across all public health institutions:

1. Research has established that, contrary to popular belief, most foreign migrants are not health migrants. Importantly, it has been shown that most migrants are healthy upon their arrival

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8 Section 27 of the South African Constitution  
9 See Appendices A (National Department of Health (a), 2007), B (National Department of Health (b), 2007) and C (Gauteng Department of Health, 2008)  
10 See Appendix B (National Department of Health (b), 2007)
in South Africa, having migrated for reasons other than health (for example economic hardship, escape conflict).

2. In terms of HIV, the view prevails that foreign migrants come to South Africa to seek treatment and that their migration to South Africa will result in an impossible burden upon an already overstretched and resource constrained public health system. However, research shows that the small – yet significant – number of foreign migrants in need of ART (a) first tested and (b) discovered their HIV positive status once they had been in South Africa for a period of time. Importantly, like South African citizens, these individuals only tested once sick. Additionally, it is important to highlight that the majority of foreign migrants travel from a country of lower HIV prevalence to South Africa, home to the highest number of people living with HIV worldwide.

3. Anecdotal evidence has pointed to the denial of healthcare services being a serious problem faced by foreign migrants. This has now been confirmed by systematic and ongoing research.\(^\text{12}\) Whilst less than half of foreign migrants report ever needing healthcare, almost 30% report encountering problems when attempting to access care (see table 1). It is clear that the main barriers constitute provider attitudes and unnecessary requests for documentation that contravene current NDOH policy and directives.\(^\text{13}\) This is supported by a study focusing specifically on access to HIV services.\(^\text{14}\)

<table>
<thead>
<tr>
<th>Table 1: Challenges reported by foreign migrants when attempting to access healthcare(^\text{15})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language problem</td>
</tr>
<tr>
<td>Treated badly by nurse</td>
</tr>
<tr>
<td>Denied treatment because of documents</td>
</tr>
<tr>
<td>Denied treatment because foreigner</td>
</tr>
<tr>
<td>Could not get treatment/medicine because of cost</td>
</tr>
<tr>
<td>Treated badly by clerk</td>
</tr>
<tr>
<td>Treated badly by doctor</td>
</tr>
<tr>
<td>Denied treatment because I have moved and no longer fall under catchment area</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

\(^{11}\) Appendices F and G
\(^{12}\) See Appendices F and G
\(^{13}\) See Appendices A (National Department of Health (a), 2007), B (National Department of Health (b), 2007) and C (Gauteng Department of Health, 2008)
\(^{14}\) Appendix G
\(^{15}\) Appendix F
4. The NDOH policy and directives are not applied uniformly across all public institutions. This has been shown through specific legal case files\textsuperscript{16} and systematic research\textsuperscript{17}.

5. Particular problems have been reported at Hillbrow Community Health Centre\textsuperscript{18}, the Johannesburg Hospital\textsuperscript{19} and Selby Hospital\textsuperscript{20} (the names of individual complainants have been withheld in this report in order to protect the identity of migrants in the current volatile South African environment. Please contact the authors of this report if you would like to reach the complainants for more details).

**Key recommendations**

The Forum therefore recommends that:

1. The Gauteng Department of Health **audits all institutional level policy** on foreign migrants, including refugees and asylum seekers, and put mechanisms in place to ensure that institutional level policies are in line with national level directives\textsuperscript{21}, policy\textsuperscript{22} and values\textsuperscript{23};

2. The Gauteng Department of Health **investigates and appropriately disciplines** public health care officials – at all levels, including institutional managers - who contravene official policy;

3. The National Department of Health, in conjunction with Gauteng Provincial Health and relevant municipal authorities, **fund and disseminate values clarification training** for all health workers – including institutional managers - on the rights of migrants to health care;

\textsuperscript{16} See Appendix E.  
\textsuperscript{17} See Appendices F and G  
\textsuperscript{18} See Appendices L and M  
\textsuperscript{19} See Appendices E and M  
\textsuperscript{20} See Appendix K  
\textsuperscript{21} See Appendices A (National Department of Health (a), 2007), B (National Department of Health (b), 2007) and C (Gauteng Department of Health, 2008)  
\textsuperscript{22} The Refugee Act (1998)  
\textsuperscript{23} The South African Constitution Preamble reads as follows: “We, the people of South Africa, Recognize the injustices of our past; Honour those who suffered for justice and freedom in our land; [...] and Believe that South Africa belongs to all who live in it”. At the same time, the Founding Provisions of the Constitution are based on “human dignity, the achievement of equality and the advancement of human rights and freedoms” as well as “non-racialism and non-sexism”.

4. The Gauteng Department of Health should **work closely** with a range of provincial and municipal level government departments and groups such as: Home Affairs, SAPS, Metro Police, Justice and Constitutional Development, Social Development. This will assist in addressing the range of interlinked needs and rights of foreign migrants;

5. The Gauteng Department of Health **establishes Migrant Helpdesks** in all health districts that will focus on providing assistance, advice and monitoring of migrant access to public health care. It is recommended that the Province liaises with and draws on lessons learnt from the City of Johannesburg's Migrant Helpdesk;

6. In addition, in an attempt to address the health impact of current xenophobic attacks in Gauteng, we recommend the following for all displaced and affected people:
   - Ensuring emergency services are deployed to areas of unrest;
   - Establishing appropriate places of safety in a sustainable environment;
   - Services available at these places of safety should include:
     a. Sanitation facilities - mobile toilets and water points for washing;
     b. Food;
     c. Blankets;
     d. Supplies for the Primary Health Care (PHC) clinics;
     e. PHC services on site; and
     f. Psychosocial services on site.
Appendix A: Memo from NDOH, 2007

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 ineligible 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 N Xuedu
Cluster Manager: HIV & AIDS, STI and TB
Appendix B: 2007 Revenue Directive from NDOH

REVENUE DIRECTIVE- REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT

To: PROVINCIAL HEALTH REVENUE MANAGERS
HIV/AIDS DIRECTORATES

10th 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 29th 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)
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

Office Number 119, 1st Floor, Hillbrow CHC Building, Corner Klein & Smit Street, Private Bag X21, Johannesburg, 2001
Tel: (011) 6943710 Fax: (011) 694 3815
Appendix D: Migrant Health Forum

A forum has recently been launched that brings together practitioners, researchers, CBOs, NGOs and advocacy groups who are involved in ensuring that the right to health is achieved for all migrants in South Africa, including refugees, asylum seekers and undocumented migrants. The forum is being coordinated through the Wellness Centre and RHRU, based within the Hillbrow Health Precinct in Johannesburg.

The aim of the forum is to monitor and act upon challenges that migrants face in trying to access public health services within South Africa, and to work towards improving this. A Health Access Monitoring Project has been launched that will contribute to the ongoing Migrant Rights Monitoring Project (MRMP) coordinated by the Forced Migration Studies Programme, University of the Witwatersrand.

**The right to health**

South Africa’s Bill of Rights entitles all people living in South Africa to a range of social services regardless of their nationality or legal status. These include access to basic education for children and emergency healthcare.

South Africa has an integrative urban refugee policy whereby refugees and asylum seekers are encouraged to self-settle and integrate, rather than be confined to camps. A range of additional rights are provided to such individuals through the Refugee Act (1998) and the South African Constitution, including basic primary health care, adequate housing, the right to work and study, and certain forms of public assistance in the form of social grants or other relevant services.

The current HIV, AIDS and STI National Strategic Plan for South Africa (NSP) specifically includes non-citizen groups, outlining their right to HIV prevention, treatment and support. Additionally, in September 2007, the National Department of Health (NDOH) released a Revenue Directive clarifying that refugees and asylum seekers – with or without a permit – shall be exempt from paying for antiretroviral treatment (ART) in the public sector. This is particularly appropriate given the right that individuals have to access ART, and the challenges that asylum seekers face in accessing documentation from the Department of Home Affairs.

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Ref: BI 4/29 REFUG/ASYL 8 2007
Some definitions

• **Refugee**: a person who flees his/her own country because of persecution on the basis of race, religion, nationality, membership of a particular social group, political opinion or civil unrest/war.

• **Asylum seeker**: a person who has applied for asylum and is awaiting a decision on his/her case.

• **Internally displaced person**: person who has been forced to flee his/her home suddenly or unexpectedly due to armed conflict, internal strife, systematic violations of human rights or natural disasters, and who is still within the territory of his/her country.

• **Economic migrant**: person who moves to another country seeking economic opportunities.

• **Undocumented migrant** (often negatively referred to as ‘illegal immigrant’): person who has entered another country and remains without the required legal documentation. The Immigration Act has officially termed this person an “illegal foreigner”.

Migrant health forum group

A web-based ‘google group’ has been established for the Forum. Please go to the following link and request to join. A request will be sent to the group manager to approve.

[http://groups.google.co.za/group/migrant-health-forum?hl=en](http://groups.google.co.za/group/migrant-health-forum?hl=en)

For further details of the forum please contact Lauren Jankelowitz at [ljankelowitz@rhru.co.za](mailto:ljankelowitz@rhru.co.za)

For additional information on the MRMP, please contact Tara Polzer at [tara.polzer@wits.ac.za](mailto:tara.polzer@wits.ac.za)
Appendix E: Submission from Lawyers for Human Rights

LAWYERS FOR HUMAN RIGHTS OBSERVATIONS RE MIGRANTS ACCESS TO HEALTH CARE MAY 2008

1. Asylum seekers and refugees with their permits are still being requested to pay a deposit, usually R1800 but this can increase to vast amounts depending on the kind of treatment required, to access medical services at State hospitals. This has been observed to be occurring primarily with the Jhb General Hospital although not exclusively.

2. There is no clarity as to what it means to have the same service available to refugees as is available to South African citizens. There is usually no explanation of the means test or how this test operates.

3. We have observed that hospital front line staff and their superiors refuse or are unable to recognize the asylum seeker permit, refugee permit and the refugee identity document. Hospital staff is inclined to treat asylum seekers and refugees as ordinary foreign patients.

4. There have been occasions where they have refused to treat children of asylum seekers and refugees even if their parents were in possession of valid documents.

5. Pre-natal and post natal care has been refused at several hospitals most notably Coronation Hospital.

6. We have heard disturbing accounts of a xenophobic and discriminatory attitude of front line and nursing staff at State Hospitals. This has been so serious that we have clients who will refuse to go to certain hospitals because of the kind of treatment they have experienced from that institution.

7. We have observed that clinic and hospital staff are not well informed of the rights of foreign patients and even where staff may be well intentioned in trying to assist foreign patients, there are instances where we have seen that they are so frustrated with a particular medical institution’s policy regarding foreign patients that this has manifested itself in poor service or a flat refusal to deal with any foreign patients.

8. We are observing that certain State hospitals who issue anti-retroviral treatment will refuse to administer these to foreign patients regardless of the type of documentation that they are in possession of. The Helen Joseph hospital contrastingly should be commended for treating all patients foreign and local in the same manner with regard to access to ARV services.

Kaajal Ramjathan-Keogh
Lawyers for Human Rights; Kaajal@lhr.org.za
Migrant Access to Health Care and Primary Education

Findings from the Migrant Rights Monitoring Project Survey
(status 05 May 2008)

Compiled by: Tara Polzer (tara.polzer@wits.ac.za)

Note on the data
These findings are based on data from a total of 1190 questionnaires of the Migration Rights Monitoring Project ‘Public Service Access’ Survey. 526 of these questionnaires were collected through partner NGOs between June and December 2007, 364 were collected at the Refugee Reception Offices at Marabastad (Pretoria) in November 2007 and 300 in Durban in February 2008. Partner NGOs include ADRO, the Bechet School in Durban, the Cape Town Refugee Centre, CARE, the Excelsior Empowerment Centre, Lawyers for Human Rights, MCC, Mthwakazi Arts and Culture, South African Red Cross Society, and the Scalabrini Centre Cape Town. The survey includes all kinds of foreign nationals living in South Africa, including a wide range of nationalities and different documentation status (undocumented, asylum seekers, refugees, permanent residents and naturalized citizens).

Because survey respondents were identified through service provider NGOs and at Refugee Reception Offices, this is data is not representative of all migrants in South Africa. However, due to the large number of respondents, spread across different cities in South Africa, the data gives us strong indications as to the kinds of health challenges migrants face, and what factors among migrants influence health care access. All comparisons made below (for example between cities, or by nationality) are statistically significant.

How can this data be used?
Data summaries like this one are intended to be used by the MRMP partner organisations. 
It is not a formal report and is not intended for distribution to the media in this format.

This information can be used in many ways, including for the development of advocacy campaigns, as a background for media work, and for internal planning by service provider organisations. The information provided here is only part of what was collected through the survey and is intended to only give an indication of what is available. The FMSP is happy to assist any partner organisation to work with the data to match it to their specific information needs.
For any questions or for further information about the MRMP and this data summary, contact Tara Polzer at Tara.polzer@wits.ac.za or tel: 011 717 4084.

**Findings on Migrant Access to Health Care**

**Need for health care**

Just under half the respondents have never needed health care since their arrival in South Africa. Factors which make a person more likely to have needed health care are a longer period of time in the country, being female, having children with them in the country, and age.

**Types of health care needs**

This kind of survey does not accurately reflect medical conditions, since it is based on self-reporting and is likely to under-count sensitive health issues such as STIs, HIV and rape related health care. Given these caveats, the main areas of health care that were mentioned by respondents were emergencies (25.1%), general health (flu, headache, stomach ache, etc.) (23.8%), and health needs related to pregnancy (10.1%).

**Health Care Providers**

Public health care providers were by far more commonly used than private providers. Public hospitals were consulted by 51% of respondents, and public clinics by 32%, while private clinics and hospitals were visited by 17% and 5% respectively. Very few respondents reported consulting pharmacies or traditional healers the last time they needed health care, but this is likely to be under-reported.

**Problems accessing health care**

72.5% of respondents said that they did not have any problems accessing health care the last time they needed it. This is a very encouraging finding, but 27.5% with problems is still too high. This would also have to be put into context with the percentage of South Africans who say they experience problems while accessing health care.

Factors which make a person less likely to have had a problem accessing health care are: having some kind of documentation (asylum or refugee papers, or work permits, permanent resident, etc.); being in the country for a longer period of time; and being employed.

There were no gender differences and no significant nationality effects (comparing Zimbabweans, Congolese and an aggregate of other nationalities) in whether someone was likely to have some kind of access problem or not.

The likelihood of experiencing problems is also not significantly different for different health care providers.

Interestingly, there seems to be a strong city effect on the likelihood of encountering problems in accessing health care. When comparing the findings from the Refugee Reception Office surveys in Gauteng and Durban, the levels of access problems in Durban are significantly higher, even when taking into account other factors.
The most important kinds of problems experienced in accessing health care were the following:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language problem</td>
<td>28%</td>
</tr>
<tr>
<td>Treated badly by nurse</td>
<td>23%</td>
</tr>
<tr>
<td>Denied treatment because of documents</td>
<td>22%</td>
</tr>
<tr>
<td>Denied treatment because foreigner</td>
<td>21%</td>
</tr>
<tr>
<td>Could not get treatment/medicine because of cost</td>
<td>16%</td>
</tr>
<tr>
<td>Treated badly by clerk</td>
<td>14%</td>
</tr>
<tr>
<td>Treated badly by doctor</td>
<td>10%</td>
</tr>
<tr>
<td>Denied treatment because I have moved and no longer fall under catchment area</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Findings on Migrant Access to Primary Education**

**How many migrants have school age children in their households in South Africa?**

Most migrants in South Africa are not looking after school-age children in South Africa (see Table 1). This is because the majority of migrants and refugees in South Africa are young men on their own. This makes the South African situation very different from most other places in Africa where the majority of refugees are women and children.

**Table 1: Percentage of respondents who have school-age children in their household in South Africa**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have school-age children in the household</td>
<td>178</td>
<td>15%</td>
</tr>
<tr>
<td>Do not have school-age children in the household</td>
<td>1007</td>
<td>85%</td>
</tr>
<tr>
<td>Total</td>
<td>1185</td>
<td></td>
</tr>
</tbody>
</table>

Women are more likely than men to be looking after school-age children, but most female migrants also do not have children with them (see Table 2).

**Table 2: Sex of adult respondent**

<table>
<thead>
<tr>
<th></th>
<th>Male respondent</th>
<th>Female respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have school-age children in the household</td>
<td>12%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Whether people have children with them in South Africa depends to some extent on how long they have been in the country (see Table 3) and how stable they are in terms of legal status (Table 4). The longer and more legally stable a person is, the more likely they are to have school-age children that they are looking after. This is important, since there is a public perception that the children of undocumented migrants are flooding the school-system, when in fact the children of non-citizens in South Africa are more likely to have legal and established parents.
Table 3: Length of time in the country

<table>
<thead>
<tr>
<th>Have school-age children in the household</th>
<th>less than 1 year</th>
<th>1-2 years</th>
<th>more than 2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6%</td>
<td>12%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Table 4: Documentation Status

<table>
<thead>
<tr>
<th>Have school-age children in the household</th>
<th>undocumented</th>
<th>asylum seeker</th>
<th>refugee</th>
<th>other temporary or permanent doc (PR, ID)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.3%</td>
<td>11.9%</td>
<td>24.7%</td>
<td>31.7%</td>
</tr>
</tbody>
</table>

Percentage of children who are not in school

The survey respondents are looking after a total of 329 children of school-going age. 62% were between 5-12 years old (primary school age) and 33% were between 13-21 years old (secondary school age). Of these children, **35% are currently not attending school.**

There is no difference between girl and boy children, concerning whether they are more or less likely to be attending school. There is also no significant difference between children whose parents have been in the country for shorter or longer periods, or for children of more or less educated parents.

However, the documentation status of the parent/caretaker does make a big difference for whether the child is in school (see Table 5). Undocumented parents are much more likely not to have their children in school than documented parents.

Table 5: Education Access by Documentation Status

<table>
<thead>
<tr>
<th>Percentage of children who are not in school</th>
<th>undocumented</th>
<th>asylum seeker</th>
<th>refugee</th>
<th>other temporary or permanent doc (PR, ID)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50%</td>
<td>38%</td>
<td>35%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Reasons for not being in school

The main reasons given for children’s non-attendance at school relate to the cost of fees (39%), lack of documentation (22%) and the costs of transport, uniforms or books (18%). This means that continued advocacy is needed concerning access to fee exemptions and educating schools about the education rights of undocumented, asylum seeker and refugee children. However, even once fees and documents are addressed, the financial burden of transport and uniforms remains a barrier to education, similarly as for poor South African children.

Table 6: Reasons why children are not in school

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
</table>

---

25 For 17 children, the age was not given.
<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>can't afford fees (annual or term)</td>
<td>47</td>
<td>39%</td>
</tr>
<tr>
<td>don't have documents</td>
<td>26</td>
<td>22%</td>
</tr>
<tr>
<td>can't afford transport/uniform/books</td>
<td>21</td>
<td>18%</td>
</tr>
<tr>
<td>school didn't give fee exemption</td>
<td>10</td>
<td>8%</td>
</tr>
<tr>
<td>schools were full</td>
<td>6</td>
<td>5%</td>
</tr>
<tr>
<td>we can't speak the language</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Our documents were rejected</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Total children not in school</strong></td>
<td>120</td>
<td>109%²⁶</td>
</tr>
</tbody>
</table>

²⁶ This adds up to more than 100% because there could be more than one reason why a child was not in school.
Appendix G: Forced Migration Studies (Wits) – Assessing non-citizen access to Anti-Retroviral Therapy (ART)

University of the Witwatersrand
Forced Migration Studies Programme

Assessing non-citizen access to antiretroviral therapy in Johannesburg

Report summary
May 2008

Jo Vearey jovearey@gmail.com
011 717 4033
Ingrid Palmary ingrid.palmary@wits.ac.za

FORD FOUNDATION
Acknowledgements
We would like to express our thanks to all participants in the study, both healthcare providers and ART clients. Without your support to the study we would not have been able to gain this insight into the challenges of non-citizen access to ART.

Many thanks to Lawyers for Human Rights, and the Ford Foundation for funding this research.

We hope that you find this summary useful; please let us know your thoughts.

Overview
This report summary provides an overview of the key findings and recommendations presented from the study “assessing non-citizen access to antiretroviral therapy in Johannesburg” conducted in 2007.

A total of 449 citizen and non-citizen ART clients were interviewed across the four sites, 2 governmental and 2 non-governmental. These sites were selected due to their proximity to migrant-dense areas of the inner city, and due to the need to access non-citizen ART clients. The client survey interviews took place between July and September 2007 and were conducted by a team of four fieldworkers that spoke a range of South African, and African, languages.

34 healthcare providers were interviewed across the four sites, and one focus group discussion was conducted with 8 refugee counsellors who work across sites in the inner city. The healthcare provider interviews were conducted between August and October 2007 by one of the researchers; these interviews were conducted in English.

Data collected from interactions with a total of 42 individuals involved in the delivery of ART services to both citizen and non-citizen clients have provided additional insights into how the parallel government and non-governmental services operate, as well as allowing for a better understanding of the challenges that healthcare providers – and health systems – face in the delivery of ARV services in inner-city Johannesburg. Importantly, these discussions provided an indication of how NDOH guidelines are
interpreted and applied in both governmental and nongovernmental clinical settings, including gaining knowledge about the different barriers to access such as whether they are primarily a result of institutional policy constraints or of the gate keeping of frontline staff.

**Executive summary**

Since the end of apartheid, migration patterns into South Africa have shifted and South Africa has become a destination for people from across the African continent and beyond; a small – but important – number of who are refugees and asylum seekers: individuals who have been forced to flee their own countries and are seeking safety in South Africa (CRMSA, 2007).

The South African Constitution guarantees 'access to health care for all' and everyone within the country is assured access to life saving health care. In the context of HIV, this guarantee should extend to HIV services, including antiretroviral therapy (ART).

The recent HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011 (Department of Health, 2007a) specifically includes refugees, and the National Department of Health (NDOH) made a statement earlier this year clarifying that patients do not need to be in possession of a South African identity book in order to access ART (Department of Health, 2007b). In addition, useful guidelines for ART provision amongst displaced populations have been produced. This is a result of collaboration between UNHCR and the Southern African HIV Clinicians Society (Southern African HIV Clinicians Society & UNHCR, 2007) and aims to supplement the National Department of Health ART Guidelines.

This research was conducted in the inner-city of Johannesburg – a migrant dense area – to better understand non-citizen access to ART in light of the above policy framework. Findings indicate that local government clinics and public sector ART roll-out sites refer non-citizens, regardless of immigration status out of the public sector and directly into a resource limited NGO sector when they are in need of ART (which in many cases is at the time of testing). This has resulted in a dual-health care system, public and nongovernmental, providing ART through separate routes, to different groups of people; citizen and non-citizen. This raises concern in terms of (1) logistical issues and (2) the responsibility of the public sector being met by NGO providers.
In September this year, a Revenue Directive from the NDOH was released, clarifying that refugees and asylum seekers – with or without a permit - shall be exempt from paying for ART services, irrespective of the site or level of institution in which these services are rendered. It is anticipated – that through effective, targeted training and awareness raising – the results of this study, combined with this recent Directive will assist in ensuring access to ART for all who need it.

**Key findings from the study**

**Non-citizens currently accessing ART in inner-city Johannesburg**

These ART clients are:

- Mostly female;
- Mostly aged 31 – 40 years;
- These individuals did not migrate for health reasons: migrants mostly first tested for HIV in South Africa;
- Like South Africans, the majority of these migrants decided to test for HIV because they were already sick;
- Most migrants therefore found out that they were HIV positive within South Africa;
- Non-citizens are referred out of the government sector and into the NGO sector;
- Only non-citizens with refugee status or permanent residence are able to access ART in the government sector;
- Non-citizens are refused access in the public sector because they do not have South African identity booklets;
- Migrants accessed treatment at particular NGO sites because they were referred there by a government clinic or a friend: migrants are accessing NGO services because government services refer them there and because migrant networks facilitate this; and
- Migrants are no more likely than South Africans to not collect or not take their ART: this provides support for the provision of ART to non-citizens.
Healthcare providers

- Impartiality of healthcare providers is threatened as they find themselves practicing within politicised spaces;
- Healthcare provision is not apolitical;
- Healthcare providers have to find innovative ways to work within the legislative framework to ensure that their humanitarian mandate is upheld;
- Healthcare providers support the need to provide appropriate healthcare to all individuals in need regardless of their citizenship;
- Refugee HIV counsellors provide important and supportive services to non-citizen ART clients;
- Healthcare providers in the NGO sector are forced to make decisions about where to refer an individual based on whether they are in possession of a South African identity booklet rather than on the need for appropriate care;
- Healthcare providers in the NGO sector raise concern at the current parallel health system that exists – for those with or without South African identity booklets – whilst recognising that the current application of legislation in public sector sites results in non-citizens without identity booklets having to access ART in the NGO sector; and
- Non-citizen staff provide an indispensable service to non-citizen clients.

Key recommendations

- Targeted training is required with public health facility managers to ensure that the recent Directive from the NDOH is implemented throughout the public sector;
- Awareness and advocacy work is required in both the health sector and with the general public in order to dispel the myth that individuals travel to South Africa for healthcare, including ART;
- HIV testing campaigns are needed in order to encourage early testing within both citizen and non-citizen communities – individuals are testing late, only when already sick;
- Appropriate and ongoing training for all health care workers – including facility managers - involved in all aspects of ART delivery relating to the rights of refugees and asylum seekers to receive treatment is urgently required;
• Dissemination and application of the UNHCR/HIV Clinicians Society of Southern Africa Clinical Guidelines on Antiretroviral Therapy Management for Displaced Populations is required;
• NDOH and UNHCR need to ensure that non-citizen counsellors with appropriate language skills are available in all ART sites;
• Future work is required to identify individuals who have not been successful in accessing ART in order to determine the challenges and determine solutions;
• Ongoing work into the best approach to the provision of healthcare for non-citizens is required – this will include debate around the current dual healthcare system provision;
• Future research to investigate the broader health and social service access challenges that this study has identified for non-citizens;
• Lobby national government to ensure that public clinic management pay attention to their NDOH directives; and
• Ongoing monitoring and reporting of the situation with the Migrant Rights Monitoring Project (MRMP) based at the Forced Migration Studies Programme, University of the Witwatersrand.
Presentation on ‘Ensuring migrant rights to health’ made on 16th May to Wits School of Public Health Academic Meeting (J Vearey).

Ensuring migrant rights to health: lessons from a study assessing non-citizen access to ART in inner-city Johannesburg

Jo Vearey
PhD Student, School of Public Health
Doctoral Research Fellow, Forced Migration Studies Programme
University of the Witwatersrand
jovearey@gmail.com  http://migration.org.za

16th May 2008

Overview of presentation

- Background
- Aims and objectives
- Methods
- Ethics
- Analysis
- Limitations of the study
- Key findings
- Key recommendations
Background (1): migration and urban health

- Almost 60% of the South African population is estimated to be urban (Kok & Collinson, 2006) and this figure is set to increase (UNFPA, 2007);
- Migration places increasing pressure on the ability of local government to respond to the public health needs of urban populations;
- The context of HIV in urban environments provides an additional challenge: prevention, testing, treatment, support;
- Understanding how to ensure and sustain the public health of urban populations is of increasing importance.

Background (2): migration & the City of Johannesburg

- Estimated population of nearly 3.9 million;
- The City has grown by 20.5% since 2001;
- Average growth rate of 4.16% per year;
- Estimated that the population will reach 5.2 million by 2015. (City of Johannesburg, 2008)
- In certain inner-city neighbourhoods, one quarter to half of residents are estimated to be international migrants (Landau, 2006; Leggett, 2003);
  - Asylum seekers
  - Refugees
  - Economic migrants
  - Undocumented migrants
Background (3): asylum policy

- South Africa has an integrative urban asylum policy:
  - No camps;
  - Refugees and asylum seekers are encouraged to self-settle and integrate;
  - This includes the right to healthcare.

- Challenges exist:
  - The Department of Home Affairs has a backlog of applications and serious barriers to accessing documentation exist (e.g. CoRMSA, 2007; Landau, 2006).
  - There is a lack of awareness of the rights of refugees and asylum seekers within the public health sector (e.g. CoRMSA, 2007; Pursell, 2006).

Background (4): Protective policy – the right to health, including ART

1. South African Constitution;
2. Refugee Act (1998);
3. HIV & AIDS and STI Strategic Plan for South Africa, 2007 – 2011 (NSP);
4. National Department of Health (NDOH) Memo (2007);
5. NDOH Directive (September 2007); and
**NDOH Memo (2007)**

- Clarifies that possession of a South African identity booklet is NOT a prerequisite for eligibility for ART.
- Important for South African citizens as well as non-citizens.

**Study aim**

To understand the extent to which different categories of migrants are able to access ART in South Africa and the barriers that may hinder their access.
Objectives

1. To find out whether migrants face greater barriers to accessing ART than South Africans;
2. To find out whether migrants access ART more inconsistently than other groups;
3. To understand what the barriers are to accessing ART for migrants;
4. To evaluate the quality of service that migrants receive compared to local South Africans; and
5. To better understand the difficulties and challenges that health care providers face in providing treatment to migrants.

Methods

1. Desk-based literature and policy review;
2. Semi-structured interviews with health care providers (n = 34);
3. Cross-sectional survey questionnaire conducted with a random sample of citizen and migrant clients (n = 449); and
4. 1 focus group discussion with 8 refugee HIV counsellors.
Ethics

- Ethical approval obtained from the University of the Witwatersrand medical ethics committee (protocol M070612)
  - Information sheet for participants;
  - Informed consent process;
  - Experienced fieldworkers.
- Permission from each site obtained
- A key challenge:
  - Ensuring confidentiality and protection of those who identify as being undocumented

Analysis

- Quantitative questionnaires:
  - $n = 449$;
  - Entered into MS excel;
  - Imported into SPSS 10.1; and
  - Analysis with SPSS, including relevant significance testing.
- Qualitative interviews and FGD:
  - $n = 34$ plus 1 FGD;
  - Digitally recorded and transcribed; and
  - Analysed for thematic content.
Limitations of the study

- Only clients who have managed to successfully access ART have been interviewed:
  - Not possible to conclude how many individuals may be in need of ART.

- Healthcare provider interviews:
  - Difficult to access clinicians.

- Institutional management:
  - Not interviewed to date;
  - Ongoing action research and dissemination process.

Key findings
Basic demographics of migrant ART clients

- Mostly female;
- Mostly aged 31 – 40 years; and
- Almost half reside in inner-city suburbs of Yeoville, Hillbrow and Berea.

Health migrants?

- These individuals are not health migrants:
  - Mostly first tested for HIV in South Africa (76%) and found out their status in South Africa (80%);
  - Came to South Africa for other reasons (qualitative follow up study);
  - Have been here for a period of time before discovering their status.

- In this study, 20% of migrants reported initiating ART in another country.....
  - Appears that other reasons (economic) are the reason for movement;
  - Further research needed – is access to ART (becoming) a determinant of migration? (qualitative follow up study);
  - Continuity of treatment.
Like South Africans, these migrants are most likely to test only when sick

Citizenship
- Citizen
- Non-citizen

Percent
- Why lost?

Migrants are no more likely than South Africans to not collect or not take their ART

Citizenship
- Citizen
- Non-citizen

Percent
- Have you ever not taken your ART?
Migrants are accessing ART in the non-governmental sector

- Only 22% of all non-citizens interviewed were accessing ART at government sites;
- The difference between the two government sites can be explained by the differences in institutional policy.

<table>
<thead>
<tr>
<th>Place</th>
<th>Government sites</th>
<th>Non-governmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>45%</td>
<td>32%</td>
</tr>
<tr>
<td>B</td>
<td>28%</td>
<td>13%</td>
</tr>
<tr>
<td>C</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>D</td>
<td>12%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Citizenship: Green = Citizen, Red = Non-citizen

A dual healthcare system

- Migrants are referred out of the public sector and into the NGO sector:
  - Reasons for this include not having a South African identity booklet and "being foreign";
  - This goes against existing legislation.

- A dual healthcare system exists for the delivery of ART: public and NGO, presenting a range of challenges:
  - Logistical issues: cross-referral, loss to follow up, workload pressure;
  - Falsification of documents... impact on adherence
  - The responsibility of the public sector is being met by NGO providers.
Health provision: a political domain?

“…..find oneself in a political situation”.

ART Clinician, NGO Site

- The policy implemented by institutional managers acts as a barrier to treatment access;
- Not simply xenophobia from frontline staff.

Quality of service

- Non-citizen staff, particularly counsellors are essential;
- Helpfulness of staff and information prior to starting ART rated highly; and
- Follow-up information rated less highly – often attributed to a lack of time.
NDOH Directive (September 2007): refugees and asylum seekers with or without a permit

1. Where refugee status has 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 Malaria test (as specified in the Annexure 1)
   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 size or level of institution where these services are rendered. (Please refer to the ART directive BI/ART dated the 20th April 2007)

Letter from Gauteng DOH

- April 2008
- Additional clarification that South African identity documents are not required for health care of ART
Migrant access to health care

Migrant Rights Monitoring Project ‘Public Service Access Survey’

- Preliminary findings from initial 1,190 questionnaires (May 2008)
  - Under half of all respondents report ever needing healthcare since their arrival in South Africa;
  - 27.5% report having experienced problems when trying to access public health care;
    - Language problem: 28%
    - Denied treatment because of documents: 22%
    - Denied treatment because foreign: 21%

Summary

1. Whilst the numbers of international migrants in need of ART are small, they are significant;
2. Existing protective legislation is not being applied uniformly across public institutions;
3. The resultant dual healthcare system presents challenges;
4. Non-citizen staff provide an essential service; and
5. HIV is a public health challenge: ensuring access to ART is upheld for all who need it within South Africa will have a population-level benefit.
Key recommendations

1. The right to health for all migrants, regardless of status, must be upheld:
   - Migrant health access monitoring project; case reporting

2. As is the case for South African citizens, campaigns must be implemented to encourage early HIV testing for non-citizens.

3. NDOH must work to ensure, through training, that protective frameworks and policies are applied uniformly across all public institutions.

4. The South African National AIDS Council (SANAC) must ensure that guidelines within the current NSP are implemented at the local level.

5. NDOH must ensure that non-citizen counsellors with appropriate language skills must be available in all ART sites.

Acknowledgements

- All study participants, both healthcare providers and ART clients
- Study sites
  - Support to the research and dissemination
- Forced Migration Studies Programme
  - Fieldworkers (survey)
  - Dr. Ingrid Palmary
  - Tara Polzer (Migrant Rights Monitoring Project)
- Lawyers for Human Rights
- Ford Foundation
Appendix H: Presentation on findings of ART programme at Nazareth House

Provision of antiretroviral therapy for migrants in Johannesburg, 2004-7

Kerrigan McCarthy
TB/HIV specialist consultant
Session doctor, Nazareth House, Yeoville

Overview

• The current crisis
  – Xenophobia, its roots, its manifestations
  – Xenophobia in health care in JHB
The current crisis
Xenophobia and health care in Johannesburg

• Last week’s lecture by Jo Veary
  – RSA has an integrative refugee policy, affording protection at many levels

The current crisis
Xenophobia and health care in Johannesburg

• Despite this.....

Migrants are accessing ART in the non-governmental sector

- Only 27% of all non-citizens interviewed were receiving ART in governmental sector
- The difference between the few government clients can be explained by the difference in institutional culture
The current crisis  
Xenophobia and health care in Johannesburg

• Health care access in the NGO sector raises concerns re:
  – quality of care
    • NGO’s at times more committed, more compassionate than public sector workers (?)
    • BUT they lack the…
  – depth of service;
    • Cannot parallel the facilities available in public sector vis à vis
      – Radiography
      – Laboratory diagnostic capability

HIV and Refugees/Migrants  
A literature review

• Factors affecting increase in HIV prevalence in sub-Saharan Africa:
  – poverty, famine, corruption, illiteracy
  – low status of women in society, polygamy, widow inheritance, child and adult prostitution, female genital cutting
  – high prevalence of sexually transmitted infections (STI),
  – internal conflicts and refugee status,
  – naive risk taking perception, resistance to sexual behaviour change antiquated beliefs, lack of recreational facilities, ignorance of individual's HIV status,
  – uncertainty of safety of blood intended for transfusion,
  – circumcision

HIV and Refugees/Migrants
A literature review

• Management of HIV is a key component of protecting Refugee health

7. Key legal principles and standards
Ensuring that human rights are respected and protected is critical both for reducing vulnerability to HIV and for mitigating its adverse effects on individuals and communities. Among human rights law contains a number of rights that are of direct relevance to those living with or otherwise affected by HIV. The rights include the right to:

- Life, liberty and security of person
- Freedom of movement and asylum
- Freedom from torture and cruel, inhuman or degrading treatment or punishment
- Right to seek and receive asylum
- Freedom of thought, conscience and religion
- Freedom of expression
- Right to privacy
- Right to health
- Right to education

In DRC, HIV prevalence is lower than in neighbouring countries. Possibly, conflict does not increase HIV prevalence BUT … post conflict may
Unexpected low prevalence of HIV among fertile women in Luanda, Angola. Does war prevent the spread of HIV?

Strand, R.T; Fernandes Dias, L; Bergström, S; Andersson, IntJSTD & AIDS,18;7:467-471(5)

- The HIV-1 prevalence
  - 1.7% in an antenatal care group (n = 517) and
  - 1.9% in a family planning group (n = 518).
  - Socioeconomic and sexual background factors did not significantly differ HIV-positive from HIV-negative women.

- While the spread of HIV may have been hampered by the long armed conflict in the country, it is feared to increase rapidly with the return of soldiers and refugees in a post-war situation.

HIV and Refugees/Migrants
A literature review

Zimbabwe and HIV prevalence
- One in five adults (20.1%) are HIV+
- Range 13.3%–27.6%; UNAIDS, 2006
- Average life expectancy (at birth)
  - Women 34 years.
  - Men, 37 years
(WHO, 2006).

- BUT....Zimbabwe
  - The only SubSA country with declining national adult HIV prevalence
  - Antenatal clinic HIV prevalence date:
    - 1996: >36%
    - 2000: 30%–32% (Harare)
    - 2004: 21%
(Mahomva et al., 2006; Hargrove et al., 2005; Mugurungi et al., 2005).

- Why?
  - Evidence of behaviour change.
  - High mortality rates
  - Social instability?
HIV and Refugees/Migrants
A literature review

• Collapse of Zimbabwean economy and health care services resulted in relocation of an estimated 2 million Zimbabweans to RSA

South African Catholics Bishops Conference in 2003 obtained funding for 14 ARV sites thro RSA

• Nazareth House in JHB, Yeoville
  – Commenced with ARV provision in March 2004 at the same time as public health sector
  – Flexibility with application of treatment protocols (though same regimens)
  – No requirements for ID
HIV and Refugees/Migrants
The Johannesburg experience

• By May 2008
  – >1000 patients on ART, over
  2000 clients on record
Yeoville is VERY poor:
- 75% earn <R38,000pa

English and non-RSA speakers account for 25% of Yeoville residents
HIV and Refugees/Migrants
The Johannesburg experience

• Clinic demographics
  – Gender distribution typical of ART clinics nationally

![Age distribution chart]

• Clinic demographics
  – But client nationality not.....
  – 42% non-RSA citizens

![Pie chart]
HIV and Refugees/Migrants
The Johannesburg experience

• RHRU Monitoring and Evaluation team
  – ‘audit’ of Nazareth House clinic files using a standardised questionnaire.....
  – April 2007 (3 years since clinic inception)
  – 1354 files reviewed over 5 days
  – For quality assurance purposes

Health provision: a political domain?

“.....find oneself in a political situation”.

ART Clinician, NGO Site
HIV and Refugees/Migrants
The Johannesburg experience

- Definitions:
  - Citizen – Recorded in the notes that the client self-identifies as South African by birth or origin.
  - Non-Citizen – Recorded in the notes that the client self-identifies as having an origin outside of South Africa.
  - No documentation or any proof of identification is required to receive medication at Nazareth House.

Citizens vs non-citizens: Demographic parameters

<table>
<thead>
<tr>
<th></th>
<th>Entire cohort (n=1354)*</th>
<th>Non-RSA citizens (n=569) 42%</th>
<th>RSA citizens (n=453) 33%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age in years (range)</td>
<td>36.2 (16-76.9)</td>
<td>37.1 (16-76.9)</td>
<td>35.9 (16.3-74)</td>
</tr>
<tr>
<td>Male gender (%)</td>
<td>482 (36)</td>
<td>237 (41)</td>
<td>148 (33)</td>
</tr>
<tr>
<td>Person-years observation at Clinic</td>
<td>893</td>
<td>205</td>
<td>439</td>
</tr>
</tbody>
</table>

*332 (24%) had unknown citizenship.
### HIV and Refugees/Migrants

#### The Johannesburg experience

#### Citizens vs non-citizens: Baseline data

<table>
<thead>
<tr>
<th></th>
<th>Non-RSA (569)</th>
<th>RSA (453)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number initiated on ART at Naz</td>
<td>235 (41)</td>
<td>139 (30)</td>
</tr>
<tr>
<td>Number presenting to Naz on ART</td>
<td>134 (23)</td>
<td>92 (20)</td>
</tr>
<tr>
<td>Mean baseline CD4 count amongst clients initiated at Naz [cells/mm³]</td>
<td>96</td>
<td>112</td>
</tr>
</tbody>
</table>

#### HIV and Refugees/Migrants

#### The Johannesburg experience

#### Citizens vs non-citizens: OIs prior to ART

<table>
<thead>
<tr>
<th>OI</th>
<th>Non-RSA (569)</th>
<th>RSA (453)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB, all forms (%)</td>
<td>188 (33)</td>
<td>202 (44)</td>
</tr>
<tr>
<td>Bacterial pneumonia (%)</td>
<td>42 (7)</td>
<td>19 (4)</td>
</tr>
<tr>
<td>Varicella zoster virus (%)</td>
<td>40 (7)</td>
<td>16 (3)</td>
</tr>
<tr>
<td>Genital ulcer disease (%)</td>
<td>26 (5)</td>
<td>12 (3)</td>
</tr>
<tr>
<td>Cryptococcosis* (%)</td>
<td>6 (1)</td>
<td>14 (3)</td>
</tr>
<tr>
<td>Kaposi’s sarcoma (%)</td>
<td>14 (2)</td>
<td>4 (1)</td>
</tr>
</tbody>
</table>

* p = 0.016
HIV and Refugees/Migrants
The Johannesburg experience

Citizens vs non-citizens: Not receiving ART

<table>
<thead>
<tr>
<th>Reason not initiated (available for 453)</th>
<th>Non-RSA (569)</th>
<th>RSA (453)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number not on ART (% of group)</td>
<td>200 (35)</td>
<td>222 (49)</td>
</tr>
<tr>
<td>Not eligible as CD4 &gt;200 (%)</td>
<td>62 (47)</td>
<td>62 (45)</td>
</tr>
<tr>
<td>Missed appointment (%)</td>
<td>36 (27)</td>
<td>52 (38)</td>
</tr>
<tr>
<td>Death (%)</td>
<td>8 (9)</td>
<td>17 (12)</td>
</tr>
<tr>
<td>Still on counseling (%)</td>
<td>26 (20)</td>
<td>6 (5)</td>
</tr>
</tbody>
</table>

HIV and Refugees/Migrants
The Johannesburg experience

Citizens vs non-citizens: ART initiation

<table>
<thead>
<tr>
<th>Initial regimen (n=660)</th>
<th>Non-RSA (569)</th>
<th>RSA (453)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>288 (82)</td>
<td>193 (91)</td>
</tr>
<tr>
<td>1b</td>
<td>62 (14)</td>
<td>7 (3)</td>
</tr>
<tr>
<td>Median time to ART initiation at Naz</td>
<td>14</td>
<td>21</td>
</tr>
</tbody>
</table>

Number receiving ART | 363 | 226 |
Initiated by doctor (%) | 231 (72) | 151 (89) |
HIV and Refugees/Migrants
The Johannesburg experience

Citizens vs non-citizens: Status on ART 1 Apr 2007

<table>
<thead>
<tr>
<th>Status</th>
<th>Non-RSA (363)</th>
<th>RSA (226)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently receiving treatment</td>
<td>323 (89)</td>
<td>166 (73)</td>
</tr>
<tr>
<td>Transferred out</td>
<td>20 (5.5)</td>
<td>32 (14)</td>
</tr>
<tr>
<td>Died</td>
<td>12 (3)</td>
<td>22 (9.7)</td>
</tr>
<tr>
<td>Unaccounted for (defaulter)</td>
<td>11 (3)</td>
<td>11 (4.8)</td>
</tr>
</tbody>
</table>

HIV and Refugees/Migrants
The Johannesburg experience

Citizens vs non-citizens: Response to ART
(Naz initiates only)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Non-RSA (235)</th>
<th>RSA (138)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean ∆CD4 after 12 months on Rx (available)</td>
<td>170 (73)</td>
<td>223 (56)</td>
</tr>
<tr>
<td>Number of patients ever failing treatment</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>
### HIV and Refugees/Migrants
#### The Johannesburg experience

#### Citizens vs non-citizens: Side effects to ART

<table>
<thead>
<tr>
<th></th>
<th>Non-RSA (363)</th>
<th>RSA (226)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment change (% of group on ART)</td>
<td>37 (10)</td>
<td>24 (10.4)</td>
</tr>
</tbody>
</table>

#### Side effects of ART (% of group)

<table>
<thead>
<tr>
<th>Side effect</th>
<th>Non-RSA (363)</th>
<th>RSA (226)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral neuropathy</td>
<td>36 (7.1)</td>
<td>16 (7.1)</td>
</tr>
<tr>
<td>Rash</td>
<td>19 (5.2)</td>
<td>21 (9.2)</td>
</tr>
<tr>
<td>Dizziness/Insomnia</td>
<td>12 (3.3)</td>
<td>10 (4.4)</td>
</tr>
<tr>
<td>Anaemia</td>
<td>1 (0.2)</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td>Lipodystrophy</td>
<td>2 (0.5)</td>
<td>0</td>
</tr>
<tr>
<td>Lactic acidosis</td>
<td>2 (0.5)</td>
<td>0</td>
</tr>
</tbody>
</table>

#### HIV and Refugees/Migrants
#### The Johannesburg experience

#### Citizens vs non-citizens: In-patient care

<table>
<thead>
<tr>
<th></th>
<th>Non-RSA (569)</th>
<th>RSA (453)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any admission noted in file (% of group)</td>
<td>88 (16)</td>
<td>129 (29)</td>
</tr>
<tr>
<td>Admitted to Naz hospice (% of group)</td>
<td>52 (9)</td>
<td>80 (17)</td>
</tr>
<tr>
<td>Mean duration of admission in days at Naz hospice (range)</td>
<td>68 (1-271)</td>
<td>89 (1-378)</td>
</tr>
</tbody>
</table>
HIV and Refugees/Migrants
The Johannesburg experience

Summary findings: Non-citizens have:
• More advanced HIV disease as evidenced by lower CD4 on entry (CD4 = 96 vs 112)
• Equivalent rates of opportunistic infections (?<TB)
• More likely to be on ART (fewer missed initiation appointments 27% vs 38%)
• Faster initiation on ART (14 vs 21 days)
• Better retention in care (89% vs 73%)
• Equivalent response to ART (7 vs 5 cases failing ART)
• Fewer admissions (16% vs 29%)
• Lower mortality on ART (3% vs 9%)

HIV and refugees/migrants
– a special group with special needs

Myths about HIV in refugees and migrants
• “Displaced persons are a nuisance and should return home”
• “Displaced persons consume our resources”
• “High mobility amongst displaced persons prevents adherence”
• “Displaced persons are different from us and should receive different treatment from us”
HIV and refugees/migrants — a special group with special needs

Myths about HIV in refugees and migrants:

- Displaced persons are a nuisance and should return home
- Displaced persons consume our resources

Cost effectiveness of ART:

- Treating WHO stage 3/4 results in savings at an individual level, ultimately at a structural level.
  - In patient days: 2.04 PPY vs 15.36 PPY
  - Cost of care: USD 964 vs USD 3520

Evidence from Naz house

- High mobility amongst displaced persons prevents adherence

Moral and ethical reasons

- Refugees, undocumented migrants and asylum seekers have better retention in HIV care, equivalent responses to ART and lower mortality than their South African compatriots
- Potential inability to access HIV care at the final destination of a displaced person does not absolve us of the need to provide care in the present
HIV and refugees/migrants
– a special group with special needs

Myths about HIV in refugees and migrants:

Humanitarian argument

- UNTRUE: Displaced persons are people like us – different through only human geo-political constructs!

- TRUE: Displaced persons are more vulnerable and need EXTRA care, (if only not to cause greater burden to their adoptive communities)

HIV and Refugees/Migrants
The Johannesburg experience

- Nazareth House...
  - A bitter-sweet success?
  - Health care should never be restricted by ethnic/geographic origins

NGOs filled a niche that should never have existed in the first place!!
Provision of antiretroviral therapy for migrants in Johannesburg, 2004-7

Nazareth House calls for
• freedom to access health care services
• by all who are resident in South Africa,
• limited only by the means test with regard to payment for services.

Nazareth House also calls for
• Improved ease of access to refugee and asylum documentation by Dept of Home affairs for non-South Africans in order to facilitate monitoring of immigration practices.

Acknowledgements:
Our patients
The staff at Nazareth House
Francois Venter
RHRU monitoring and evaluation team
Matthew Chersich
Appendix I: Submission from RHRU, University of the Witwatersrand

RHRU fully supports the individual’s right to access to treatment, and firmly believes that this should not be denied. To this end, RHRU has worked to promote the right to access with all the sites in which it works. RHRU would like to acknowledge that the Department of Health leadership at a local, provincial and national level also supports these beliefs.

Most recently, in April 2008, the office of Dr Maduna; Chief Director for Johannesburg Metro has circulated a letter instructing health workers to provide access to all who need it. RHRU has played a part in communicating this obligation, both in the sites in which it works, and in trainings and other forums where health care workers participate, in order to ensure the broadest dissemination possible.

Nevertheless, anecdotal accounts from our staff working in Department of Health sites suggest that access may still be an issue. However, whether these accounts suggest a routine and recent occurrence, given significant recent attempts by Department of Health and other stakeholders including ourselves to enforce rights to access, would require a more detailed, evidence based investigation. We would be happy to do this on the request of the Department of Health, and would utilize the Migrant Health Monitoring Forum’s case report to assist us in this process.
Appendix J: CoRMSA

CoRMSA has been receiving reports from a number of organisations regarding the difficulties that asylum seekers/refugees and other migrants encounter when trying to access healthcare in the province. Most of the information came from organisations working in the Johannesburg Metro area. The one hospital that organisations have raised concerns about is the Johannesburg General Hospital. CoRMSA with other stakeholders met with the CEO of Joburg Gen in order to address the concerns raised. He promised to look into the matter and ensure that staff at the hospital adhere to the DoHealth Directive that was issued in Sept 2007. Organisations continue to monitor the situation in many health facilities, but there are still a lot of challenges that are faced. CoRMSA is looking at engaging the Provincial office of DoH to address issues and concerns that have been raised.
Appendix K: Statement from mother of baby patient C

(translated and transcribed)

Usindiso Ministries Shelter for Women, Johannesburg Inner-city

(name withheld to protect identity)

It started at 14 January 2008. My baby was doing diary [diarrhea] for 2 days, then I decided to bring him to the clinic behind the shelter. From there the doctor looked at him and said that, they must send him to Johannesburg Hospital. At Johannesburg Hospital they did all the examination, they found nothing wrong with the baby. They sent us to Selby park hospital for children because the baby was having fever and diary. At Selby park hospital the baby was hospitalized they kept the baby for 6 days, they told me that I can not stay with the baby they have to keep him. So I was going to visit him every day there and I noticed that the diary was not finishing.

On the 20th of January 2008 I went there as usual to see the baby and they told me that he is fine I can take him home with me, when I asked them about the diary they said that it was going to finish. They gave me 2 bottles of medicine [amoxul liquid]. I left with the baby at home around 18hoo. I tried to give him some food (porridge). He vomited all the food at 19h30. I tried again. Same thing happen and that was all night vomiting and diary. He was becoming very weak. In the morning I went back at the clinic. They told me that there is nothing they can do for the baby. They gave him me a serum to give the baby. We were there at the clinic for the whole day and they decided to call the ambulance. From the morning till late at 15h00 the baby died and the ambulance arrived at 15h45. The baby was already dead.

The name of the doctor: Dr Naka
Tel: 011 491 4194/4195
Selby Park Hospital
Appendix L: Statement from Wits medical student

(name withheld to protect identity)

I am a medical student currently working in the Hillbrow Community Health Clinic. I have observed a number of instances of abusive and unethical behaviour by members of the South African nursing staff towards non-South Africans in the maternity ward and others at HCHC. Examples that I have witnessed include:

- One specific nurse in the maternity ward shouting at patients and verbally abusing them. Female patients are often chastised for becoming pregnant and interrogated about where their wedding rings are;
- Immunisation clinic staff shouting at mothers who bring their babies for immunization; and
- On the 19th of May 2008, at +16h50 in the afternoon a Congolese patient was in labour and was instructed to stay in a chair despite extreme discomfort and beds being available. Minutes before she delivered, she was only allowed onto the bed.
Appendix M: Extract from TAC’s *Equal Treatment*

This article was taken from the Treatment Action Campaign publication *Equal Treatment* which focused on xenophobia. The publication can be downloaded from http://www.tac.org.za/community/files/file/et25.pdf
TREATMENT INTERRUPTED

Equal Treatment spoke to a Zimbabwean woman in Johannesburg who was denied access to antiretroviral treatment.

34-year-old Edwina Nyamhangu, originally from Zimbabwe, has been living in South Africa for 18 years. She has learnt to speak Zulu fluently. After being diagnosed with TB, Grace chose to get an HIV test. She tested positive in September 2007 with a CD4 count of 42. After her test she was referred to Johannesburg General Hospital. The hospital staff illegally refused to give her antiretroviral treatment because she was foreign and did not have citizenship papers.

Foreign nationals who cannot pay have the right to access free and comprehensive HIV treatment, care and support. You do not need asylum-seeker or refugee papers.
Paula Chirundu* is a 34-year-old Zimbabwean refugee woman living with HIV. Her husband passed away in 2007 so she stays with her sister in Johannesburg. She has three children who are still living in Zimbabwe. Paula was diagnosed with HIV in May 2007 and started taking antiretrovirals (ARVs) while in Zimbabwe.

Paula does not have a passport. She came through the border illegally. She was detained a short while later and imprisoned at Mosewe Police Station for 20 days. Her ARVs ran out and she was not able to access more in prison. After her release, she went to Hillbrow Hospital in Johannesburg to try and get more ARVs. They refused to give her any because she was not from South Africa. She spent another three months without ARVs until she began to get sick. She went to the Central Methodist Church and was referred by Bishop Paul Verein to Nazareth House for treatment. Here she was seen by a doctor. Her CD4 count was 116. She was restarted on ARVs and now her CD4 count is going up. She is healthier now. Her greatest challenge is to get enough food because she does not work full time. Paula would like to go back to Zimbabwe if the situation gets better.

*Not her real name.

A treatment interruption is when someone on antiretrovirals stops taking them. This might be because the person chooses to stop treatment or for reasons out of their control like being detained in a Migrant Detention Centre. Some immigrants in South Africa active having had to stop treatment because supplies of antiretrovirals (ARVs) have run out in their home countries. Some immigrants have been denied treatment in the public sector.

Adhering to ARV treatment is very important. Once you have started treatment you should not stop. You should also try to take the drugs at around the same time everyday.

A treatment interruption can have serious health implications. A person could develop a strain of HIV that is resistant to their ARVs. Resistance occurs when the virus mutates when it reproduces so that one or more ARVs no longer work against it.
Appendix N: Note on unnatural causes of death among migrants

Compiled by Lorena Núñez and based on an interview held at the Johannesburg Medicolegal Laboratory on the 26th of May, 2008

As comprehensive statistics are not yet available, the number of migrants who die every year of unnatural causes in South Africa cannot be precisely established. However a percentage of them remain as unidentified bodies at the various South African mortuaries.

Experts at the Johannesburg Medicolegal Laboratory estimate the percentages of unidentified and unclaimed bodies they routinely examine to determine the cause of death as fluctuating between 10 and 25%, throughout the year. It is the fact that bodies remain unclaimed that gives grounds for speculation that they belong to internal or to foreign migrants. Presumably, having migrated alone, they do not have families who may be able to identify and claim their bodies. It has also been observed that the majority of this unidentified group are male and black.

As reported, there has been significant increase in the numbers of violent deaths in Southern Gauteng Forensic Pathology Service Mortuaries since the onset of the wave of xenophobic attacks particularly on the East Rand.

Authorities at the Johannesburg Medicolegal Laboratory are currently making efforts to implement a unifying system to gather statistics from the various mortuaries in Gauteng. They are also planning to make their information on unidentified bodies more accessible through the internet, on a Gauteng Department of Health weblink, as a way to facilitate their identification and assist families in finding their deceased members.

Access to reliable information will facilitate further research on the topic and enable us to produce more accurate information about migrants who die of unnatural causes in South Africa.

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27 Unnatural causes of death included here are accidents, homicides, suicides and other undetermined causes.
28 In the case of unidentified bodies the standard procedure is to keep them for 30 days, before they are buried. During that period an investigation is conducted by the police and involves searching for family members. In addition fingerprints are sent to the Department of Home Affairs for possible identification. As bodies are buried procedures also secure that enough information is obtained for an eventual future identification (pictures of the face, fingerprints and samples to obtain DNA information are taken).
References


