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Access to HIV/AIDS Health Services by Refugees in the Eastern Cape, South Africa

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The ECSECC Working Paper Series was launched as a platform for publishing work in progress in areas broadly aligned with the strategic objectives of the Eastern Cape Socio-Economic Consultative Council. Contributions are invited from ECSECC stakeholder communities as well as independent researchers/writers who share an interest in ECSECC's overarching objectives.

Access to HIV/AIDS Health Services by Refugees in the Eastern Cape, South Africa

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Foreword

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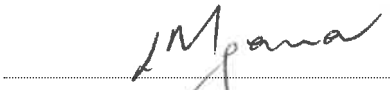
The Eastern Cape AIDS Council (ECAC) is a multi-sectoral body representing government departments and civil society formations. The purpose of the council is to effectively manage the province's multi-sectoral response to HIV/AIDS, TB and STIs. ECSECC provides strategic and technical support to ECACs members and coordinates HIV/AIDS related programmes and donor funding.

Working paper 22 is a product of desktop research by the Eastern Cape AIDS Council (ECAC) and information shared by the Agency for Refugee Education, Skills Training and Advocacy (ARESTA) on availability and accessibility of HIV-related services amongst refugees. The paper was developed to assess the access to basic healthcare and HIV/AIDS services by refugees in the Eastern Cape. Recommendations based on this paper has been shared with ECACs stakeholders.



Mr Luvuyo Mosana
ECSECC CEO

Abstract

Despite the availability of numerous policy documents that stipulate and advocate for the rights of refugees to access basic healthcare in South Africa, HIV/AIDS treatment and services are still not easily accessible to refugees. A number of challenges exist that make access to HIV/AIDS services difficult for refugees in the Eastern Cape Province of South Africa.

Based on three research workshops conducted with refugees in the Eastern Cape, it was discovered that there are specific issues and challenges that hinder the access to HIV/AIDS services by refugees. These challenges include language barriers between health care providers and refugees, cultural issues that make accessing sexual reproductive health and HIV/AIDS services difficult, for Muslim refugees in particular, and institutional ignorance of refugee documents and refugee health rights which hinder access to HIV/AIDS services by refugees.

Healthcare institutions need to educate their staff on refugee issues and refugee health rights, so that refugees can freely and openly access HV/AIDS services without stigma or discrimination. Healthcare institutions also need to also take into account the language and cultural issues that affect many refugees, and to provide relevant interpreters and information that is culture-specific, so that refugees do not feel isolated and are able to seek HIV/AIDS information and services.

Introduction

Migration of people from one region to another in search of opportunities that will ensure their survival is an age-old custom. A distinction can be made between those who flee their countries of origin because of wars/conflicts or persecution (refugees) and those displaced by natural disasters or in search of better economic opportunities (populations of humanitarian concern).

Political unrest, domestic wars, poverty, the search for jobs and a better lifestyle, are some of the factors that lead to widespread migration of people from one country to another. These migrations, be they within a country or across the country's borders, can contribute to epidemics. Migrating people can be vectors, carrying disease from one place to another (Iqbal, 2006). This high mobility provides fertile ground for the spread of diseases, and in recent years, particularly HIV/AIDS.

Unfortunately, history shows that more often than not, refugees are blamed for unfortunate events that befall the host community, especially the spread of diseases (Spiegel & Nankoe2004).

A Colonial and Apartheid-Era Regional History of Labour Migration

- The consistently high rate of migration from SADC countries is due to a colonial and apartheid-era regional history of labour migration especially from Mozambique, Lesotho, Malawi, Zimbabwe and Swaziland
- South Africa is regarded as an important destination for many people who seek better socio-economic opportunities due its relatively stable democratic government, good infrastructure and economic stability
- Political unrest, economic instability and even environmental degradation in the African region have resulted in increased numbers of displaced persons, increasing the number of both documented and undocumented migrants in South Africa and other middle- and high-income countries globally.

StatsSA: Migration Dynamics

Provision of health services, especially HIV education, counselling and treatment, is an integral part of caring for refugees. This is a unique population that needs the host country to make concerted efforts to ensure the design of appropriate programmes that address their health needs.

This may also lead to greater uptake of HIV-related services (Mills, Singh, Nelson & Nachega, 2006). Depending on the level of resourcefulness, or lack thereof, of the newly found habitat or host country; or because of restrictions or lack of access to resources for newcomers; refugees may become more vulnerable to diseases. Such restrictions may not only affect the refugees, but because they live amongst the host country citizens, could also have a negative impact on the society at large.

Examples include introduction and spread of a biological agent, such as a virus or bacteria, by newcomers to a community because they have restricted or no access to healthcare services. The reverse is also true, where newcomers have little or no immunity to existing health threats in their host environment. Because of lack of, or limited access to necessary services, they become susceptible to such health threats.

The breakdown of the social fabric among people living in migrant communities also makes them more prone to social ills. This may be because of their illegal status, unemployment, barriers to economic development opportunities, or other negative behaviours. Moreover, their lack of proper documentation may negatively affect their access to social and health services.

Where Migrants to South Africa Come From

Region		%	
Africa	Africa SADC	68.0	75.3
	Africa other	7.3	
Asia			4.7
Europe			8.2
Latin America and The Caribbean			0.3
North America			0.3
Oceania			0.2
Unspecified			11

Source: Census 2011

Net Immigration to South Africa

- The annual level of net immigration (net migration is the difference between immigration and emigration) for South Africa stood at 96 000 per year for the period between 1990 and 2000
- It then rose dramatically to 247 000 annually between 2000 and 2010.

UN Department of Economic and Social Affairs
International Migration Report for 2013

In some host countries, refugees are often placed in remote and inaccessible areas with limited services, especially HIV-related programmes (UNAIDS & UNHCR,

2005). The displacement of families, the death of parents and/or breadwinners may expose women and children to sexual violence or force them to join the sex trade just to survive. Women in displaced communities, especially in war-torn regions, are the most vulnerable. Sexual violence, often committed against women, is also an age-old part of warfare.

There are numerous well-documented cases of militiamen raping women of opposing communities, from Europe to the former USSR, South-East Asia, down to Africa.

The Top Migrant "Sending Countries"

- Zimbabwe, Mozambique, Lesotho, Malawi, Swaziland and Namibia were among the top 10 "sending countries" (countries of origin of migrants) in 2016, together with the United Kingdom, Democratic Republic of Congo, Nigeria and India.
- Zimbabwe and Mozambique contribute the largest number of international migrants.
- Lesotho is the highest by proportion; almost half of working age Basotho men work in South Africa.

StatsSA 2016 Community Survey

Policies Related to Refugee Treatment

The 1951 Convention on the Status of Refugees clearly states that host countries must provide same and equal public relief and assistance as that accorded their own nationals, including medical and health services, without discrimination.

The 2002-2004 UNHCR Strategic Plan on HIV/AIDS honours refugees' human rights by ensuring that they live in dignity without being discriminated against, and that they receive basic health care that includes coordinated HIV/AIDS programmes (UNHCR, 2002).

The 2005-2007 UNHCR Strategic Plan further calls for integration of refugees into HIV policies, funding proposals and programmes of the countries where asylum has been sought, as well as considering the needs of refugee women and children and the mainstreaming of gender and the aged (UNHCR, 2005).

In South Africa the health rights of refugees are protected under section 27, sub-section (g) of the Refugee Act No 130 of 1998.

Refugees and Asylum-Seekers in South Africa in 2014

- There were over 65,500 refugees
- There were 230,000 asylum-seekers
- Major countries of origin for refugees were Somalia, the DRC, Angola and Ethiopia

StatsSA 2014

Handling of HIV/AIDS in Developing Versus Developed Countries

A study conducted on refugees in Nakivale Refugee Settlement in south western Uganda showed that survival requirements preceded concern to access HIV testing (O'Laughlin, Rouhani, Faustin & Ware (2013).

Lack of food was highlighted as one of the barriers to overall health, with some refugees missing clinic appointments to go to work to avoid losing out on a day's wages in order to provide food for their families. Also, the hardship of having to endure long trips and spending a lot of money on transport are other reasons for inconsistency in their health seeking behaviour.

For many, seeking HIV services, especially testing, only became a priority when one was severely sick. When incentives like food were provided and clinic services were offered for free in the refugee camp, travel costs and time-wasting were eliminated.

In the years prior to 2010, the USA passed a law forcing refugees to get tested for HIV before they could be granted entry into that country. That law has however since been revoked and since January 2010, refugees are no longer required to test for HIV before arrival in the country (CDC, 2012).

It is now rather recommended that persons between 13-64 years of age be screened for HIV on arrival, with the option to opt out. For refugees who were exposed recently, or engaged in high risk activities, a repeat screening at 3-6 months is recommended.

Submissions to 2018 SA Human Rights Commission Hearings into Xenophobia

- South Africa faced a "peculiar situation" because 76% of asylum seekers appealing their statuses were young males
- Asylum seekers from Ethiopia, Bangladesh and West Africa were mostly males between the ages of 19 and 36 seeking economic opportunities
- SA went against the "global trend" which saw mixed groups of refugees appealing their statuses, including mothers, children and elderly people
- SA's "96% rejection rate" referred to asylum seekers who had already said they were in South Africa for economic purposes". Home Affairs could not grant them refugee statuses based on this
- Home Affairs had a backlog of about 140 000 appeal cases and many legitimate appeals were currently stuck in that backlog.

SAHRC, February 2018

In Canada, an application for permanent immigration by an HIV positive person may be difficult on the grounds of medical inadmissibility. This is because of the risk of "excessive demand" that is used by immigration authorities to decline permanent residency applications on medical grounds.

However, this does not apply to refugees and/or people with sponsors, either a spouse or child, who are Canadian citizens or permanent residents (Canadian HIV/AIDS legal network, 2015). Entry to the United Kingdom, on the other hand, does not require mandatory HIV testing, nor does it require declaration of one's HIV status (Dodds & Weatherburn, 2010).

Access to HIV Services by Refugees in South Africa

Since the dawn of democracy in 1994, South Africa has experienced a huge influx of both legal and illegal immigrants into the country seeking better job and lifestyle opportunities. In most cases, the immigrants left their countries because of wars and political unrest, and therefore are asylum seekers. Some however merely moved from their countries in search of better economic opportunities.

Porous South African borders make it easy for illegal immigrants to enter the country undetected. This results in an expanded population, which, because it is not properly documented, is not officially recognised by government systems, leading to the underserving of migrant communities. Although South Africa has policies that cater for all people within its borders, migrants' access to much needed services may be limited by lack of knowledge of, as well as means to access such services.

The Universal Declaration of Human Rights states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care (UN, 1948).

In 2007, the South African National Department of Health released a statement affirming the right to access ART by foreign nationals, irrespective of their legal status, and that they should be provided with free health care should they lack the financial capacity to pay for themselves (Odendal, 2010). Although South African law guarantees refugees and asylum seekers access to antiretroviral treatment (ART), people still reported being turned away from health facilities because of lack of South African citizenship documentation (Amon & Todrys, 2009). Such violations of refugees' rights to mental and physical healthcare are perpetrated by healthcare professionals (Randolph, 2012).

A number of articles have appeared in the media describing how refugees are refused healthcare, either because of lack of proper documentation or because they cannot foot the bill. As recently as 2014, an SABC article written by Hasina Gori, revealed that a Gauteng Department of Health guideline entitled 'non-citizens guidelines' stated that: "hospitals should demand full and upfront payment from patients without permits or refugee documents, or who are asylum seekers". Even when patients produce the Section 22 asylum seeker permit, some staff turn them away, claiming that they have never seen it before.

Percentage of Foreign-Born Residents per Province

Province	%
Gauteng	6
Western Cape	3.1
Mpumalanga	2.7
Limpopo	2.3
Free State	1.9
North West	1.4
Northern Cape	1.4
Eastern Cape	0.8
KZN	0.8

StatsSA Community Survey 2016

Experiences of Refugees in The Eastern Cape

In three workshops on refugees and HIV/AIDS, it emerged that the challenges that hindered the use of health and HIV/AIDS services by refugees fell into three categories: linguistic, cultural and institutional. The workshops involved a total of 75 participants, who included 29 females and 46 males, from Ethiopia, Somalia, Burundi, and the Democratic Republic of Congo. The participants broadly expressed their dissatisfaction with the South African healthcare system, and in particular HIV/AIDS programmes and interventions which they believed were not tailored to suit and assist refugees.

The language barrier was listed as a major obstacle because most refugees come from non-English speaking countries and found it hard to express themselves when seeking medical assistance on HIV counselling and testing (HCT) and treatment information. Another challenge that hindered positive HIV/AIDS outcomes amongst refugees was cultural. Many refugees in South Africa are from predominantly Muslim countries, where it is taboo to discuss issues of sexual reproductive health, HIV/AIDS, condom use and infidelity. Discussion of health issues around HIV/AIDS is not encouraged within such communities. If you disclose your HIV-positive status to the community and/or family members, there is a high chance that you will be stigmatised and discriminated against. Participants stated that they did not feel comfortable testing for HIV as this could be misconstrued as promiscuity or having a dubious HIV status.

Another challenge was health care workers' attitudes and ignorance of refugee and asylum seeker documents. According to the refugees, many health workers at health facilities were ignorant of refugee status documents, as well as of the health rights of refugees. They were consequently often turned away from health institutions without accessing the required health services. Many other refugees felt victimised and discriminated against by healthcare workers who called them derogatory names and mocked their experiences, while taunting them to return to their country as they were not welcome in South Africa.

Conclusion

South Africa, as a country with a sizeable population of refugees, needs to include and integrate refugee healthcare into its national, provincial and district HIV, TB and STI strategic plans. Encouraging HIV testing by using HIV positive refugees as peer educators who demonstrate health and vitality, may decrease stigma and discrimination associated with being HIV positive.

Making HIV services accessible to refugees through shortened waiting times at health facilities, as well ending refusal of services due to lack of citizenship documentation, can also improve HIV services uptake. Denying refugees access to healthcare not only negatively affects them, but also has far reaching implications for the entire public health system.

By providing refugees with good quality healthcare, their chances of creating livelihoods for themselves may improve, thereby contributing to the country's economy and ultimately reducing the burden on the public health system.

Since daily survival is the top most priority for refugees, providing incentives like food and other basic supplies to refugees can increase the uptake of HIV services as they will not miss important clinic appointments.

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