

Refugees' Perceptions of their Health Status & Quality of Health Care Services in Durban, South Africa: A Community-Based Survey

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EXECUTIVE SUMMARY

Background: There is anecdotal evidence from refugees that health care services in South Africa are not responsive to their perceived needs.

Objective: To evaluate the perceptions and opinions of refugees about the health care services in South Africa and to make recommendations to the officials, NGOs and social networks involved in the health care of refugee communities.

Design & Methods: qualitative and quantitative approaches were used. Focus group discussions were held from which a structured questionnaire was developed. Respondents to the questionnaire were purposively sampled. SPSS and STATA V9.2 software were used for data entry and analysis.

Results: A total of 52 respondents took part in six focus group discussions and 250 survey questionnaires were administered. Thirteen themes were generated and grouped as strong, medium or weak issues according to the order of their importance as expressed by the respondents. Strong issues included discrimination and xenophobic attitudes towards refugees; language as barrier; “maternity as hell” for refugee women; increase vulnerability of refugee children; problems with refugee permits; and promotion of self-medication among refugees. Medium issues were lack of support system for refugees; disappointment and lack of hope; lack of structures and appropriate organizations in helping refugees; and physical illnesses brought by refugee newcomers. Weak issues were problems in the referral system; and cultural differences between refugees and host communities. Data from focus group discussions were supported by the questionnaire survey.

Conclusion: The key findings showed that the refugee community is diverse and complex including their health related problems. Therefore, diverse and complex approaches need to be taken into consideration in order to overcome the problems they experience.

ACRONYMS

AHPO: African Health Provider Organization
DRC: Democratic Republic of Congo
FGDs: Focus Group Discussions
HCWs: Health Care Workers
HST: Health Systems Trust
HIV: Human immune-deficiency virus
NGO: Non-Government Organization
OAU: Organization of African Unity
PHC: Primary Health Care
SA: South Africa
STIs: Sexually Transmitted Infections
UNHCR: United Nations High Commissioner for Refugees
UN: United Nations

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INTRODUCTION

Health problems experienced by the majority of displaced population, either through natural catastrophes or man-made disasters pose major challenges for public health systems worldwide.⁴ The diversity of problems experienced by refugees requires diverse approaches, including diseases surveillance, control and prevention.

Political and security factors often prevent accurate documentation of these problems as well causing a number of deaths among refugee populations. Health status and factors affecting the health of refugees have not been widely documented.⁴ In Mozambique (1993), Ethiopia (1984-1985), and Sudan (1988), crude mortality rates estimated by surveillance and population based surveys of displaced persons ranged between 4 and 70 times the death rates of the host population within the same country. The highest death rates were in infants under one year of age.

Refugees are found in most African countries; and refugee health services are usually set up and provided separately by international organizations such as the United Nations High Commissioner for Refugees (UNHCR).³ Integrated refugee and host health services, however, are reported in a few African countries such as in South Africa and West Nile districts in Uganda.^{3,7} The success of these integrated health services remains doubtful because refugees consistently face discrimination and xenophobic attitudes^{8,9} from these health services. Inappropriate treatment due to the language barrier between refugees and health care workers (HCWs) is possible and is a concern.¹¹ The presence of “illegal refugees” makes the situation worse as these refugees may not attend a public hospital for health care.^{6,8,9} The 1998 South African Refugee Act and the regulations to the South African Refugee Act¹⁰ require a refugee to apply for temporary residence permits within the first days of entering South Africa. Registered refugees receive “Status” after two successful interviews and then an “Identity document” as well as the United Nations convention travel document.

There are several reasons for some refugees to be classified as “illegal refugees”. These include

- The increasing number of refugees whose permits are delayed;⁶
- Failed interviews due to language barrier;
- Rejection of an applicant without justifications;⁶
- An application thought to be unfounded, abused or fraudulent;
- Illegal crossing of borders without being inspected by an immigration officer during the process of displacement and
- Legal entry with subsequent violation of terms of the visa.

The status and rights of such individuals are a source of debate. A refugees’ health status is worsened by the increased vulnerability of this population. Females may be

raped, children abused, exploited and malnourished, and all are more susceptible to communicable diseases during the process of displacement. Refugees are traumatised daily and prone to depression. ^{3, 1, 9} Even where the mortality and morbidity rates of refugee communities are within expected and acceptable levels it does not imply that health services are offered in a culturally appropriate and acceptable way. ^{4, 9}

RATIONALE OF THE PROJECT

There is anecdotal evidence from refugees and service providers that health services in South Africa are not responsive to refugees' perceived needs. Problem areas include discrimination and xenophobic attitudes during service provision, ^{8, 9} language barriers (many refugees are French, Portuguese and Swahili speaking), inappropriate treatments due to misunderstanding, ¹¹ exclusion from public hospitals due to lack of valid permits or delay in the delivery of such permits, ^{6, 8, 9} and increased perinatal and infant mortality among refugee's children. ^{12, 13} In South Africa, refugees mix freely with the local population with potentially high risk of transmission of communicable diseases if refugees' health status is not properly evaluated and managed. Improving refugees' health services and health status, therefore, could potentially improve the health of the general community.

There is limited published data on the main health-related problems faced by refugees in South Africa and the care they receive for these. Systematic analysis of refugees' experiences and perceptions of the health care system is required.

RESEARCH QUESTION

What are the main problems affecting the health of refugee communities in Durban, South Africa and how do government agencies, the health services and non-government agencies working in the field meet the needs of these communities?

OBJECTIVES

- (1) To explore refugees' major health-related problems in Durban, South Africa
- (2) To analyze the impact of such problems on the affected individuals as well as on the host community
- (3) To evaluate refugees' perceptions, views and opinions towards the health care services
- (4) To make recommendations from the findings as a "guide" to the officials, NGOs and social networks involved in the health of refugee communities.

METHODOLOGY

Qualitative and quantitative methods with triangulation were used according to the following steps:

Qualitative Study

Focus group discussions (FGDs) were held with selected groups, including

- Refugee community leaders
- Church leaders
- NGO staffs involved in refugee affairs
- Refugee women and adolescent groups
- Refugees' health skilled committee members and
- Caregivers of refugee children.

Each FGD had six to 12 participants. A total of six FGDs were held at which time data generation had reached saturation point.

Facilitators of FGDs were trained on issues such as language nuances during interviews, comprehension and approach to the focus topic, recording interviews and taking notes, reflecting content and feelings, asking appropriate follow up questions and remaining non-judgemental. The duration of each FGD was 90 minutes and groups were homogenous in composition to facilitate greater freedom of expression.

All discussions were recorded using a voice-recorder, and notes prepared immediately after the meeting. Data were generated as textual narrative from transcribed interviews and written descriptions of observations and reflections.

A coding system of themes and sub-themes was used to recognize persistent words, phrases and observations and stored in an analytic file. The data generated from the FGDs were used to construct a questionnaire for a population-based survey.

Quantitative Study

A structured questionnaire was used to collect data. Since the refugees were from different countries and to overcome language nuances, the questionnaire was administered by an interviewer as opposed to being self-administered.

There is a lack of accurate statistical data on legal and “illegal refugees” and, therefore, non-probability sampling was used. Purposive sampling of intentionally selected

subjects was used. Sample size was estimated using guidelines for sampling published by Stoker DJ.²

Analytical and descriptive analysis was used for socio-demographic data. SPSS and STATA V9.2 statistical programmes were used for data entry and analysis.

Ethical Considerations

The study was approved in September 2006 by the Biomedical Research Ethics Committee of the College of Health Sciences at the University of KwaZulu-Natal (Ref. E 101/06). Consent forms were signed by all participants for both qualitative and quantitative studies, and confidentiality was maintained throughout the study.

RESULTS

Qualitative study

Demographic characteristics of respondents

A total of 52 respondents from the six FGDs participated in the first stage of the study. Nearly two thirds (61%) of respondents were males with majority in the 31-40 age groups. Most females were in the younger age groups (Figure 1).

All respondents had more than Grade 7 (Standard 5) level of education and about half (44%) had a tertiary level of education.

Two thirds of respondents (58%) were from the Democratic Republic of Congo (DRC). Most respondents lived in the inner city areas of Durban.

Thirty-five percent of respondents were students and 23% self-employed. Seventeen percent were employed in private sectors against 6% in the public sector. Fifteen percent of respondents, with a majority of females (13%), were unemployed.

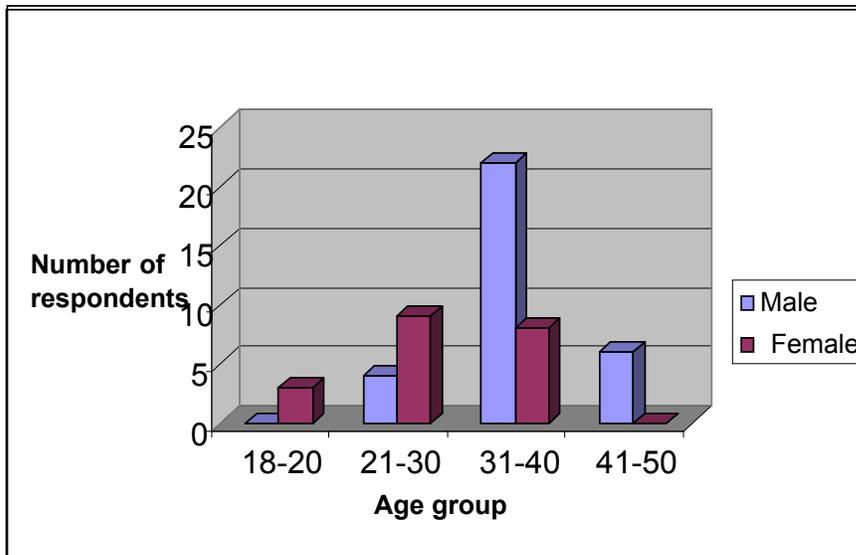


Figure 1: Age and gender distribution of the respondents

Refugees' perceptions of their health status and quality of health care services provided to them

Thirteen themes were identified in the analysis of the interviews. These were divided into three sub-sections of **Strong**, **Medium** and **Weak Issues**. Allocation of issues to each sub-section was done on the basis of importance as expressed by respondents in the interviews and from field notes.

STRONG ISSUES

1. Discrimination & xenophobic attitudes towards refugees

In public hospitals, refugees felt that they are often prevented from seeing doctors and getting "proper" treatment. Language differences with black nurses, who act as "gatekeepers" to the doctors, are the starting point of non-acceptance. Most refugees are black and there is an expectation that they speak Zulu as a black South African language. Because they cannot, they feel they are rejected by health workers. Showing a refugee permit is seen as a trigger for non-acceptance. Refugees may be discharged without clear diagnoses and are always given analgesics irrespectively of the type of complaints presented. Refugees, even with valid permits, may be rejected by health care workers; females are more frequently rejected than males.

2. Language as barrier for refugees

When admitted to public hospitals, language is found to be a barrier to appropriate treatment and follow-up. Refugees do not feel confident to ask questions regarding their health condition.

3. Increased vulnerability of refugee women in health care facilities

Refugee women face several problems. They face non-acceptance in health care facilities and even death due to lack of effective post-partum follow up. Counselling and antenatal education are done in Zulu and an HIV test is performed without informed consent. In addition, laboratory results are given without clear explanations. Pregnant women are forced to have a caesarean section. This is considered to be culturally wrong as their understanding from knowledge gained in their home country is that caesarean sections are only used in cases of extreme emergencies.

4. Increased vulnerability of refugee children

Poor nutritional status of refugee children and lack of assistance to their mothers during and after delivery could explain the increased mortality rates among this sample of refugee children in Durban. Out of 100 live children borne by this sample of women refugees, 16 had died before the age of five.

Refugee children also lack access to early childhood development facilities such as a day care centres. If left unattended while their parents are working, their safety is compromised.

5. Problems with refugees permits in Durban

HCWs in public hospitals are perceived not to understand refugee permits. The health facilities charge refugees as foreigners and the refugees are therefore asked to pay higher fees. Refugee permits are difficult to obtain and respondents reported that Department of Home Affairs were corrupt and asked for bribes if the refugee wanted their papers processed quickly.

6. Promotion of self-medication by refugees in Durban

This is one of the important business markets developed for refugees by refugees. Respondents explained that this developed due to the lack of good care when attending public hospitals.

MEDIUM ISSUES

1. Lack of support system for refugees

Refugees are granted permits and are left to find a way to integrate into the community and to survive. Data shows that lack of employment, poor conditions of work, lack of accommodation, an unclean environment and poor nutrition adversely affect the health status of the refugees.

2. Disappointment and lack of hope among refugees

Refugees feel rejected and ill-treated when attending public hospitals. The majority have decided to no longer attend public hospitals.

3. Lack of structures & appropriate organizations in helping refugees

Refugees interviewed agreed that national and international organisations are not addressing their problems. There are no services in South Africa to support and guide them.

4. Diseases brought into South Africa by new refugees

Refugees may enter South Africa with tropical illnesses that are unknown to the South African HCWs. They agreed that the diagnosis of such conditions is often delayed.

WEAK ISSUES

1. Problems experienced in referral system

Refugees rarely request transfer to another health facility as this is usually organised by doctors to whom they feel they have little access. Refugees may move to another hospital without referral when their treatment has failed.

2. Cultural differences between refugees and host communities

Refugees do not understand the reasons for the negative attitude of their host communities towards them, including in public hospitals. This barrier, according to some refugees, may be cultural and may engender a lack of self esteem among the refugees thus preventing good assimilation of the refugees into the local community.

Quantitative study

Demographic characteristics of respondents

A total of 250 respondents, selected from various areas, participated in the second stage of the project. Half (51%) of the respondents were male. The majority participants were in the 31-40 age group as shown in Figure 2. Most respondents had more than a grade seven level of education with one-third of them having a tertiary level. Half (50%) of respondents were married with about 40% remaining single. The remaining 10% were divorced or widowed.

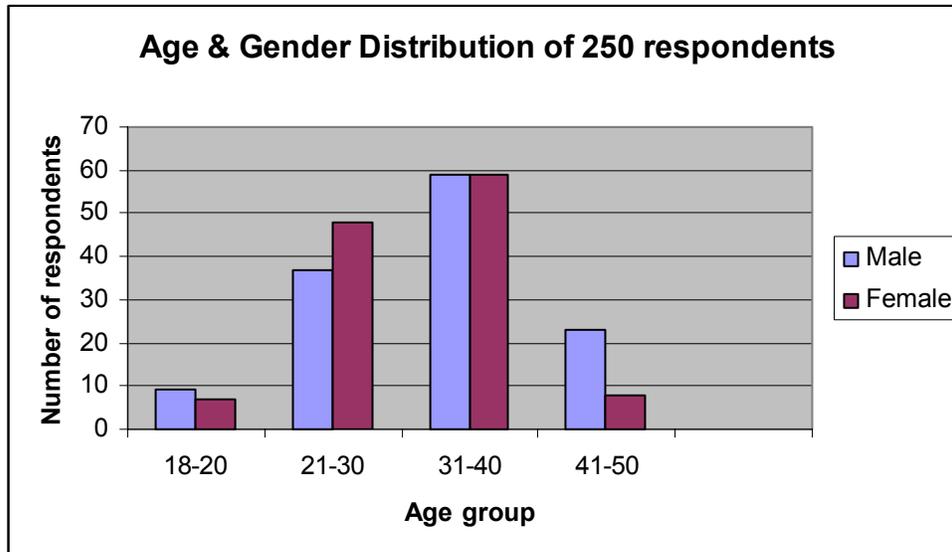


Figure 2

Figure 3 shows that 135 respondents (54%) were from Democratic Republic of Congo, 59 (25%) from Burundi and 30 (12%) from Rwanda.

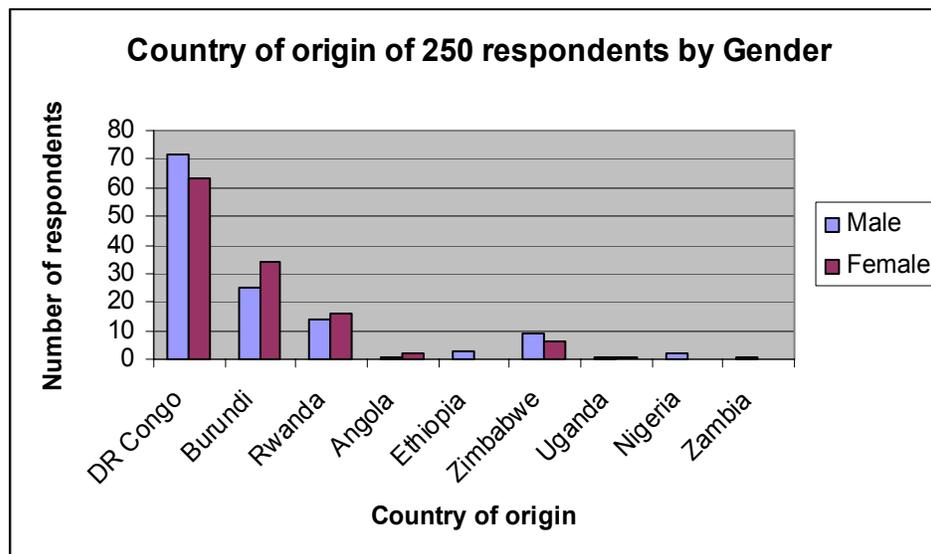


Figure 3

Most respondents (92%) were living in flats with about half (41%) of them sharing residence. More than 5 people occupied a flat. Fifty-two percent of respondents had lived for less than 12 months in their area of residence.

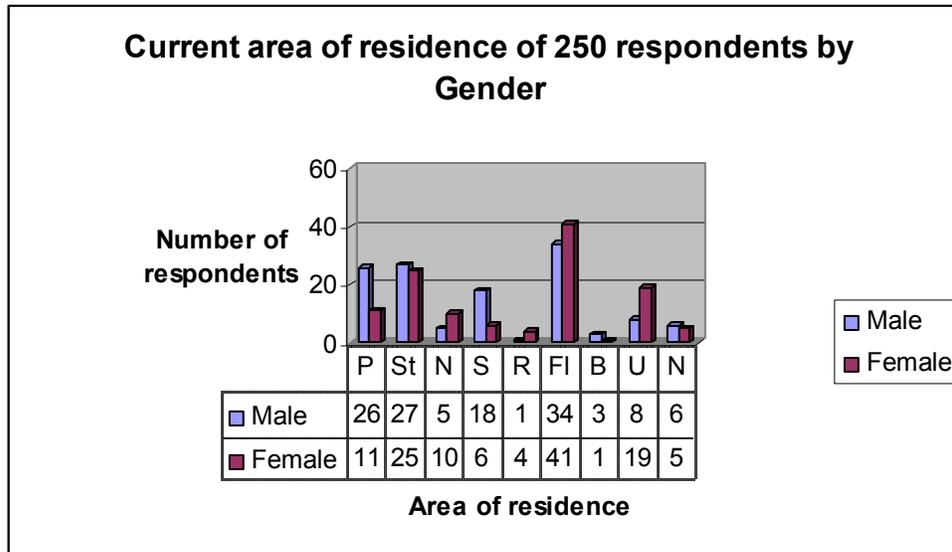


Figure 4

Of the refugees sharing residence with friends, 18% were sharing a flat with South Africans. A further 18% reported that they had previously shared a flat with South African friends but were not doing so at the time of the study.

Almost half (44%) the refugees in the sample were unemployed and 30% were self-employed. Prior to coming to South Africa, only 19% of the refugees were without jobs, 22% of them were employed in the private sector and 15% in public sector (See Figure 5).

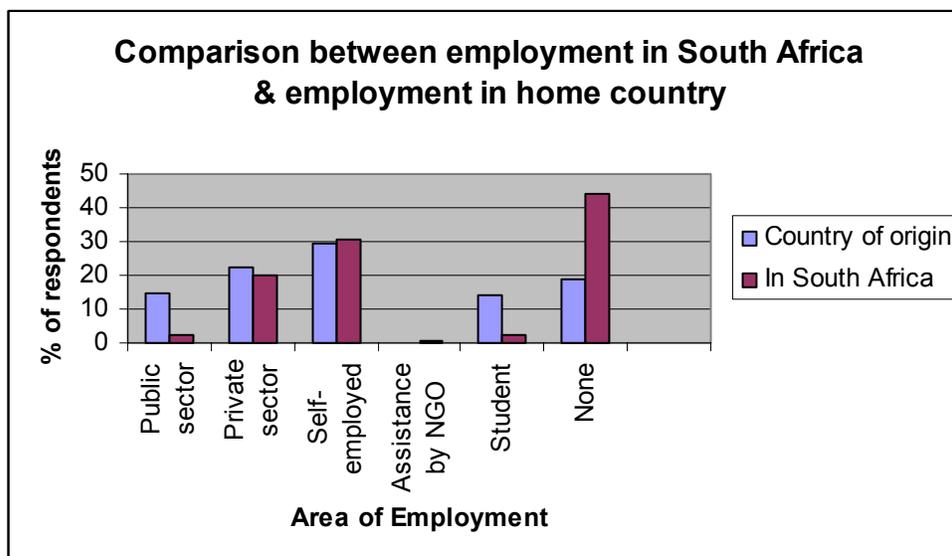


Figure 5

Refugees' perceptions of their health status and the quality of health care services provided to them

Seventy-nine percent of refugees reported having valid refugee permits and 4% did not have a valid permit. Six percent of refugees were using expired documents and 11% reported that their permits had been delayed by the Department of Home Affairs without apparent justification.

The majority of respondents (68%) strongly agreed that lack of “valid permit” is an important argument used by public hospital officials in order to preclude refugees from receiving attention. Most refugees justified their decision to not attend public hospitals by saying they were not welcomed (87%) in such institutions, they were unable to communicate (76%), and their permits were seen as invalid (49%).

Refugees reported that treatment received from public hospitals is less helpful than it could be due to miscommunication (65%), discrimination (87%), lack of trust (71%), and lack of good referral system (38%) and absence of translators (74%). Eight percent of refugees attend only private hospitals. Reasons given for attending private hospitals included: discrimination by public hospitals (32%), inappropriate treatment (28%), lack of “valid permits” (26%), language barrier (10%) and poor referral system (2%).

Promotion of self-medication was reported by the majority of respondents, and many used self-medication because of treatment failure commonly observed while attending public hospitals (82%) or for illnesses brought from their home countries which are unknown to South African health care workers (76%).

A discussion was held with participants regarding how their health care needs may be met. There was strong agreement that creation of primary health care centres for refugees would help in alleviating refugees' health related problems. In addition, involving foreign HCWs in their care would overcome language barriers and also help in making the diagnosis of illnesses with which South African health care workers are unfamiliar. Finally, improving the nutritional status of refugees children was rated as very important.

Eighty-one percent of the refugees rated the quality of health care provided to them in public hospitals as very poor. Sixty-seven percent rated their living environment and 37% the quality of water supply as not being conducive to a healthy life. More than 80% reported that their children aged less than 6 years were poorly nourished; and 74% reported that the quality of day care centres for their children is very poor and is unaffordable. Eighty-four percent of the respondents reported that they had never been assisted in any way since their arrival in South Africa. Only 16% of refugees agreed that they had been assisted; half of these (8%) received food assistance, 4% financial assistance, 3% scholarship for students and 1% received clothes. According to 28% of respondents, refugees mobilise themselves to assist each other during difficult times.

Eighty percent of female refugees and 65% of males reported that pregnant refugee women are forced to have caesarean section for delivery of their babies. Ninety-five percent of women and 82% of men rated health care services for pregnant refugee women as very poor.

DISCUSSION

Data show that health problems experienced by refugees are complex in their origin and remain among the greatest public health challenges worldwide.⁴ This is true also for the refugees in Durban, who report multiple inter-related issues affecting their health and the health care they receive.

Results from the focus group discussions correspond with data published by Amisi *et al*¹⁴ who found that there are fewer females than males in the refugee community in Durban. This was not seen among the respondents to the questionnaires. However, the non-probability sampling method used for the questionnaires may account for this difference. The majority of respondents in this study were young. The Mail & Guardian newspaper, reporting on the South African National Survey on Refugees and Asylum seekers in 2003¹⁵ reported that the average age of exiles was 31 years. The results confirm that young individuals, particularly males, are mobile and able to migrate more easily during difficult times. They accept the risk of travelling without proper documents; will resist police arrests and shootings during illegal border crossing and withstand the illnesses they may suffer during the process of displacement.¹⁴

All respondents had Grade 7 or higher level of education, with the majority having a tertiary education. Although purposive sampling was used, the results correspond with those found by Amisi *et al* (2006) in which 47% of respondents had some tertiary education; and by the Mail & Guardian (2003) Survey, where about one-third of refugees were tertiary level students in their home countries before migrating.

Data show that single refugees were mainly females, possibly because refugee females prefer to not be married as this may prevent them from earning money through prostitution.¹¹ More than half of our respondents were from the Democratic Republic of Congo. Since 1999, according to UNHCR statistical year book¹⁶ the majority of refugees in South Africa are from the Democratic Republic of Congo, followed by Somalia, Angola, Burundi and Rwanda.

Refugees in Durban mix freely with the local population. Amisi *et al* reported that 26% of Congolese refugees shared accommodation with South African citizens. The results of this study showed that 36% of refugees at one time shared accommodation with South Africans which suggests that there are interactions between refugees and their host communities. Ninety-two percent of respondents shared accommodation with more than five other refugees. As many refugees as possible live together in order to share the cost of rental. This results in overcrowding which negatively affects their health.

More than half of the respondents had lived for less than 12 months in their current place of residence, and the lack of a support system may explain why some refugees do not stay in one place for long; this would add to their rejection in public hospitals as proof of residence is an important requirement.

One-third of refugees were self-employed and this category involved mostly car-guards because of the flexible working conditions and secure environments. Semi-skilled people, such as artisans, were involved in repair of appliances and electronics. Private companies employ refugees (20%) as they are hard workers and are more skilled.¹⁵ This, however, causes discrimination and xenophobic attitude towards the refugees by the local community who accuse the refugees of taking their jobs. Few refugees (2%) in this study were working in the public sector because of controversies over refugee permits; it seems level of education of refugees is not considered when applying for employment.¹¹ Forty-four percent of refugees, of which 30% are females, are without jobs. Females may refuse to risk working without proper documents and thus avoid police arrests. In addition, jobs available for refugees are not easy for females. They reported, for example, that working as a security guard is very dangerous for them because of the long hours, lack of social protection and bad working conditions such as rain and cold.

There is a proliferation of churches within refugee communities and 19% of the male refugees in this study were Church leaders. A possible explanation for this is that the refugees place their hope in God for protection and healing of illnesses. They see little hope in human organisations for social protection neither do they trust the health care workers.

Only 6% of the male refugees were actively involved in NGOs. The negative perceptions of the role played by NGOs have been discussed elsewhere.¹⁴ Their perceptions were that many NGOs working with refugees do not involve the refugees in their work and, therefore, do not understand the real problems faced by the refugees. In addition, they felt that some exploit refugees and use the money donated to the NGO for their own purposes rather than providing services to refugees.¹¹

Eight percent of the refugees visited private hospitals. Most of the refugees, however, would have liked to attend private hospitals because of the poor quality of services received in public hospitals. However, the cost of private health care precluded them from doing so. As it is, refugees may be charged more than South Africans at public hospitals but receive less help.

Problems faced by the refugees in public hospitals include discrimination and xenophobic attitudes (32%), language barriers with treatment failure (28%) and lack of a valid permit (26%). Respondents also agreed that their cases are seldom treated as emergencies. One-third of participants expressed the fear that they may see even emergency treatment stopped if their permits expired.

Amisi *et al*¹⁴ reported a similar finding that Congolese refugees were rejected at public hospitals and none of their cases was taken as urgent.

The lack of translators for refugees in public hospitals is a further contributing factor to inappropriate treatment being given. An HIV test is performed without consent of the refugee. This may be due to the language barrier experienced during counselling. According to 50% of respondents overcrowding in public hospitals has a negative impact on their proper management because HCWs do not have time to spend in trying to understand them. However, 33% of respondent reported the lack of interest from HCWs was experienced particularly in public hospitals and not in private health centres where they received better treatment and management. The negative attitude of black nurses towards refugees is a concern. The nurses often prevent refugees from consulting with the doctors. Respondents called black nurses “small gods” because they decide on the health service outcomes for refugees.

Delays in transferring refugee patients when admitted in public hospitals was reported and claims made that this is due to lack of policies for referral. Proof of residence is one of the requirements for hospitalisation and referral. Refugee permits report place of residence as “no fixed address”. This tends to make the situation worse for the refugees.

According to most respondents, good communication and better understanding of tropical diseases are essential to improve the management of their illnesses. These will not only facilitate diagnosis but will improve the trust between the refugee and HCW as well as improve the psychological support to refugees who are often depressed and vulnerable. Respondents reported that mismanagement of the tropical diseases brought by some refugees in to South Africa is due to the inexperience of HCWs in managing these conditions and contributes to the higher mortality rate among refugees. Most respondents believe that primary health care facilities, managed by foreign HCWs, would be the best solution to the problems. Good management of tropical diseases brought into the country would prevent South Africans being exposed, especially with communicable diseases as refugees, at times, share accommodation with the local people.

The concept “Maternity as hell” is used purposefully in order to summarize difficulties faced by refugee women while attending public hospitals. The vulnerability of women to rape, abuse and exploitation is a well known phenomenon in the context of war and displacement. Refugee women are not only exposed to STIs, including HIV infection, but they are also victims of unwanted pregnancies. Culturally women from Central Africa are not able to freely access abortion services. They prefer keeping their pregnancies even though they are unwanted. Respondents said that counselling and antenatal education is done in Zulu and that HIV test is done without informed consent or even without counselling. In addition, explanations are not given to them on the results of tests that are done. Refugee women are frequently psychologically depressed from the process of displacement and are constantly wrongly blamed by nurses for being pregnant. They feel that they are forced to have caesarean sections. This practice is seen as not culturally correct as such operations are reserved for extreme emergencies according to their knowledge from home. Twenty-five percent of respondents believe that there are no clear indications for a caesarean section in many cases.

Refugees perceived maternal and neonatal mortality rates to be higher among their communities in Durban; and they contribute this to refugees being rejected, the language barrier in maternities and the lack of good care during birth and post-partum. Finally, the vulnerability of female refugees is increased because they are unable to pay for crèche for their children and have to stay and take care of their children alone. This precludes them from looking for jobs in order to make money to provide food for themselves and their children. This situation may partially explain the higher mortality rates due to poor nutritional conditions associated with refugee children as described above.

Self-medication is an important business developed by refugees for refugees. Respondents justified this because of their disappointment with and ill-treatment experienced in public hospitals.

The majority of the refugees had valid permits and only 4% were without permits. Six percent had expired permits and 10% had their permits delayed by the Department of Home Affairs. The majority of the refugees strongly agreed that the controversy with the validity of their permits is an important argument used by public hospital officials to avoid providing services to them.

On entering South Africa, refugees are granted a permit and are asked to find a way to integrate in to the community. This, however, is not practical, especially for newcomers, due to the lack of a support system. This may explain the importance of social, religious and economic networks developed by refugees to support each other and survive. Data show that lack of employment or inhumane conditions of work, lack of accommodation or living in unclean environment as well as poor nutritional conditions negatively affect the health status of refugees. Refugees are prone to develop physical illnesses and are under daily psychological pressure. More than half of the respondents believed that the delay in issuing permits by the Department of Home Affairs precluded them from being attended to in public hospitals because they are seen as being illegal. The refugees, therefore, develop initiatives such as collecting money through their networks or hold fund raising activities so that they are able to take those who are sick to private hospitals. Unfortunately, even then they usually are not able to afford the high costs of private hospitals.

The support refugees expect from international organisations, such as UNHCR, depends on their experiences of the support these organisations offer refugees in other countries, as well their knowledge of the 1951 UN convention and the 1969 OAU Protocol of African Refugees. These organisations claim to take care of refugees in a holistic manner.¹⁴ Most refugees, however, are totally ignorant of the 1998 South African Refugee Act and the Regulations to the this Act that clarify the agreement between UNHCR and the South African government.¹⁰ Respondents agreed that they do not know the way UNHCR operates in South Africa and two thirds of them requested clarification of their rights. They would also like to see international organisations active in the field.

There are no services to guide refugees after their arrival in South Africa and most of HCWs and hospital administrators do not know anything about refugee permits. The refugees would like hospital managers to be informed of the rights of refugees.

CONCLUSION & RECOMMENDATIONS

This is the first comprehensive study in Durban, South Africa able to describe the understanding of refugees' perceptions of their health status and quality of health care services provided to refugee populations. The key findings revealed that refugee community is diverse and complex as well as are their health related conditions. Therefore, diverse and complex approaches need to be taken into consideration in order to overcome such problems.

Refugees deserve workshops in order to understand the South African Refugees Acts and their regulations. They require at least a baseline health related interview and check-up so that their needs on integrating into the community may be ascertained. This should preferably be done in a primary health care (PHC) centre dedicated to refugees. The community integration process should also involve learning SA local languages to overcome language barriers and facilitate integration. Refugee support systems for refugees should be established, such as day care centres allowing their guardians or parents to go out and search for jobs. Health care workers should also be informed through workshop sessions about issues such as refugee permits and policies regarding referral systems. Public hospitals should employ qualified translators to help in cases that are referred from PHC centres for refugees.

Figure 6 represents a flow diagram of recommendations as suggested by the African Health Provider Organization to the governmental agencies, health systems and non-government agencies such as NGOs or individuals involved in refugees' health related affairs.

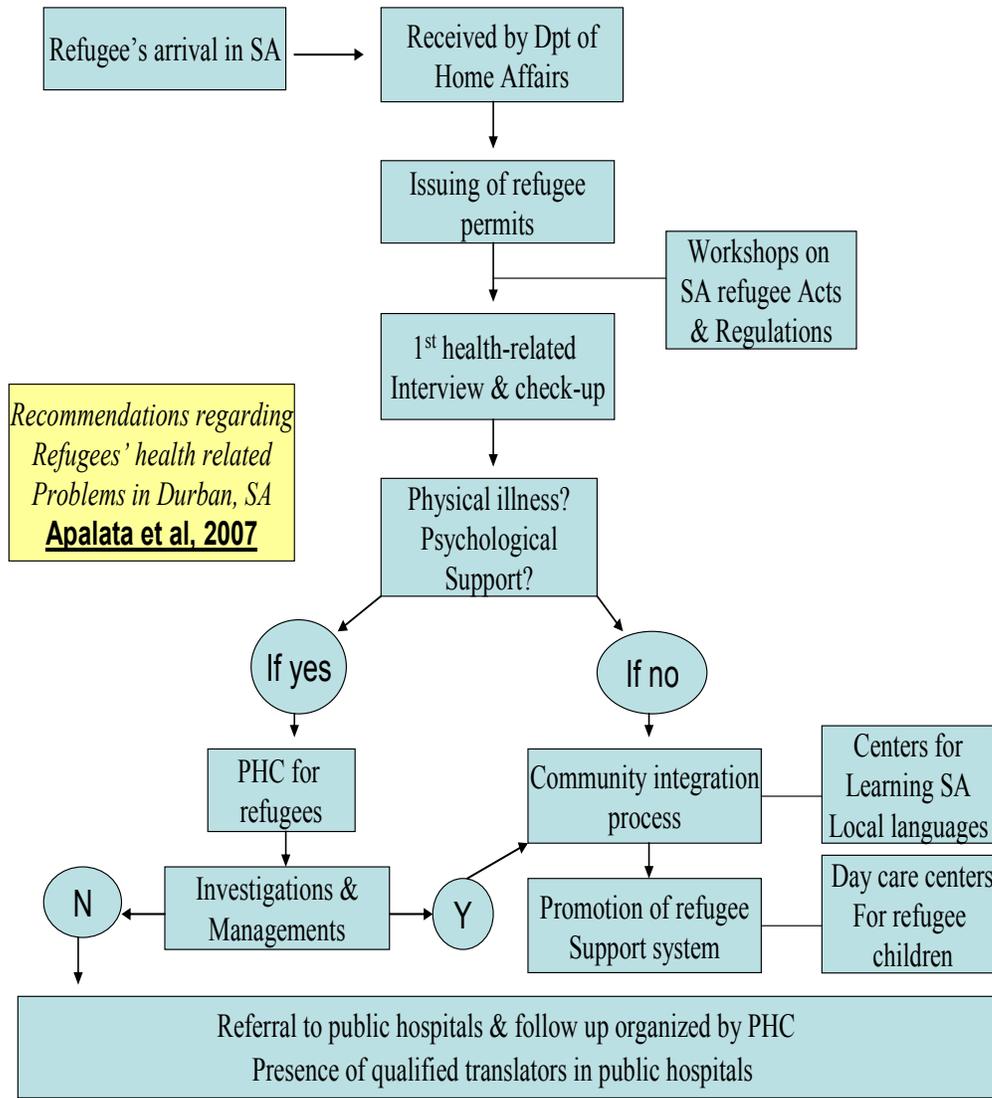


Figure 6: Suggested flow of refugees on entering South Africa.

LIMITATIONS OF THE STUDY

The use of purposive sampling limits the generalisability of this study.

REFERENCES

1. JM Katzenellenbogen, G Joubert, SS Abdool Karim: Epidemiology; a manual for South Africa; Oxford University Press Southern Africa, 1997: 176-184
2. AS de Vos *et al*: Research at Grass roots; a primer for the caring profession; Van Schaik Publishers, 2001; 357-418
3. Christopher Garimoi Orach and Vincent De Brouwere: Integrating refugees and host health services in West-Nile districts, Uganda; Health policy and planning advance. Access originally published on line on December 7, 2005. Health Policy and Planning 2006 21(1):53-64; doi: 10.1093/heapol/czj007
4. Mike J Toole, MD *et al*: Famine-affected, refugees and displaced populations: recommendations for public health issues; US department of health and human services public health services, CDC Atlanta, Georgia 30333; July 24, 1992 41/ (RR-13); 001
5. Training guide on qualitative methods developed by John Hopkins University: www.jhsph.edu/refugee/ressources.html
6. www.hrv.org : Georgette Gagnon (Deputy Africa Director of Human rights watch): human rights news, Johannesburg, November 17, 2005
7. Huissen Solomon: strategic perspectives on illegal immigration into South Africa; African security review vol. 5(4), 1996
8. Vicki Robinson: Health-South Africa: ARVs elusive for refugees and illegal immigrants; the story underneath (Inter Press Service News Agency); Friday, May 12, 2006; 18:34 GMT
9. Bronwyn Harris: A foreign experience: violence, crime and xenophobia during South Africa's transition; Violence and Transition series, vol. 5; August 2001
10. Government Gazette (1998): The Refugee Acts of 1998, № 1558: Government Printers. Pretoria, Republic of South Africa; Volume 402, No. 19544(No. 130 of 1998) Government Gazette (2001): The immigration Act of 2001, Government Printers. Pretoria. Regulations to the South African Refugees Act: Government Notice Department of Home Affairs; No. R 366; 6 April 2000(Schedule-Arrangement of Regulations)
11. Teke Apalata (African Health Provider Organization): A personal communication; interviews with refugees attending Prince Cyril Zulu Communicable Diseases in Durban and a three day interviews with refugee community at Point road area in Durban; January, 10-12, 2006

12. Hargreaves (James-R): Childhood mortality among former Mozambican refugees and their hosts in rural South Africa: Perinatal and pediatric epidemiology; international journal of Epidemiology, Vol 33; 6. P. 127-1278; 23 Ref.
13. www.infoforhealth.org : Vol 2, No. 32 Pop. Reporter, August 2002
14. Amisi B B.: An exploration of the livelihood strategies of Durban Congolese Refugees. New issues in refugee research; School of Development studies and the centre for civil society; University of KwaZulu-Natal, Durban, South Africa. Working paper No. 123 (available online); February 2006
15. Mail & Guardian (on line, 2003): National survey: Most of refugees in South Africa are skilled. 11 December 2003
16. www.unhcr.org/statistics/hr2005