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MPhil in Social Justice | PBL5649W

Barriers to access to mental health care services in the Cape Metropole, faced by refugee and asylum seeker women who have been exposed to trauma



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Research dissertation presented for the approval of Senate in fulfilment of part of the requirements for the Masters in Social Justice in approved courses and a minor dissertation. The other part of the requirement for this qualification was the completion of a programme of courses.

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ABSTRACT

Through use of a phenomenological design, this qualitative study investigated barriers to accessing mental health care by female refugees living in the Cape Metropole who have mental health problems as a result of exposure to trauma. A high number of female refugees in the Cape Metropole have been exposed to trauma. This study aims to contribute to the limited literature on this topic. The objectives of the study were to identify whether female refugees faced barriers to accessing mental health services in the Cape and if they did, the nature of these barriers. The findings identified that at the service-delivery level, language, under-resourced mental health services, documentation barriers and lack of awareness of refugees' rights were the biggest barriers. The main barriers in the refugee communities were cultural and religious, fear and lack of awareness and work and childcare responsibilities. The study highlights that not only is the South African government obliged under international, regional and national laws to fulfil female refugees' right to access mental health services, but it is in the state's best interests to do so.

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CHAPTER ONE: INTRODUCTION

...One client of mine said ‘You know it’s all very well getting a place to stay, or getting an option to learn English or whatever, but until you feel like a person, you can’t do anything with it’. So for her it was through recovery in counselling that she was able to actually focus enough to learn English; to be able to feel strong enough to approach someone for a job or even another member of the refugee community... to speak to someone. When you do have a disorder, I’m not talking about just the general human suffering, when you have a disorder... you, you can’t make the kind of contacts that you need... and because you’re in a different country and you don’t speak the language, your isolation makes it more likely that you are going to have to live on hand-outs of some kind, rather than being able to stand up for yourself. (Morgan, Trauma Counsellor, Cape Town)

1. Introduction

There is a large refugee¹ and asylum seeker² population in the Cape Metropole³. Many of these refugees⁴ have been exposed to and continue to be exposed to trauma⁵. As a result of this trauma, a number of them have mental health disorders⁶.

When initially investigating the prevalence of exposure to trauma and the extent of mental illness amongst refugees in Cape Town, I discussed this issue with refugee

-
- 1 A refugee is anyone who has fled their country of nationality ‘owing to [a] well-founded fear of being persecuted’ and has been granted refugee status in an asylum state. (Art 1(a)(2) of The 1951 United Nations Convention and 1967 Protocol Relating to the Status of Refugees)
 - 2 An asylum seeker is an individual who is still seeking refugee status in another country. (Human Rights Education Associates (HREA) ‘Refugees and Displaced Persons’ (2011), available at http://www.hrea.org/index.php?doc_id=418.)
 - 3 The Cape Metropole is an area in the Western Cape, South Africa. It includes Cape Town, the Southern Peninsula, Blaauwberg, Helderberg, Tygerberg and Oostenberg (Table Mountain Properties ‘South Africa’s Western Cape: The Cape Metropole’ (2005), available at <http://www.capetownhomes.com/tmp03.htm>.); also see Said Penda ‘Little Welcome for Refugees in SA’ *BBC News* 22 June 2006, available at <http://news.bbc.co.uk/2/hi/5103456.stm>.
 - 4 Throughout this paper the term ‘refugees’ will be used to refer to ‘refugees and asylum seekers’ unless I am exclusively referring to one group.
 - 5 McColl, Helen et al ‘Rehabilitation of torture survivors in five countries: common themes and challenges’ (2010) 4(16) *International Journal of Mental Health Systems*, available at <http://www.ijmhs.com/content/4/1/16>; also see IRIN ‘Migration: Trauma travels too’ 22 May 2012, available at <http://www.irinnews.org/report/95498/MIGRATION-Trauma-travels-too>; also see Chennels, Rebecca, 27 July 2012, personal communication (discussion); also see Sarah, 1 August 2012, personal communication (discussion); also see Mitchell, Morgan, 2 August 2012, personal communication (discussion).
 - 6 A mental health disorder may be referred to as any prolonged disruption of an individual’s thoughts, moods or behaviour (University of Michigan ‘What is Mental Health?’ (2012), available at http://hr.umich.edu/mhealthy/programs/mental_emotional/understandingu/learn/mental_health.html.); also see J.D. Kinzie. ‘Immigrants and Refugees – The Psychiatric Perspective’ (2006) 43 *Transcultural Psychiatry* at 577; and also see K, Bhui et al ‘Traumatic events, migration characteristics and psychiatric symptoms among Somali refugees: Preliminary communication’ (2003) 38 *Social Psychiatry and Psychiatric Epidemiology* 35-43; also see IRIN op cit note 5; also see UCT Refugee Rights Clinic Booklet ‘Do you need mental health counselling?’ available at http://www.refugeerights.uct.ac.za/usr/refugee/Information_Sources/RRPbooklet_complete.pdf; also see Anna-Clara, Hollander et al ‘Gender-related mental health differences between refugees and non-refugee immigrants - across-sectional register-based study’ (2011) in 11(180) *BMC Public Health*, available at <http://www.biomedcentral.com/1471-2458/11/180>.

agencies. They acknowledged the high incidence of mental health disorders and exposure to trauma amongst the refugees they see⁷. However, a number of them mentioned seeing more male refugees accessing mental health services than female refugees⁸. They suggested this could be due to various barriers to access faced by these females⁹. It is this topic that I address in my thesis.

2. Study Aim and Objectives

My informal interactions with service providers raised the question:

What are the barriers to access to mental healthcare services in the Cape Metropole, faced by refugee women who have been exposed to trauma?

My study aims to answer this question by determining whether female refugees, who have been exposed to trauma, face barriers to accessing mental health care in the Cape Metropole. If such barriers exist, it further aims to explore the nature of these barriers. In line with this aim the objectives of this study are:

- To identify the right of female refugees, living in the Cape Metropole to access public mental health care services.
- To identify government policies relating to the promotion and protection of this right.
- To determine whether and in what ways this right is being upheld and promoted.
- To identify areas in which this right is not being upheld and promoted.
- To establish what other barriers may be hindering access to public mental health care services.

3. Contextual Background

According to the United Nations High Commissioner for Refugees (UNHCR) in January 2012 there were 413, 040 refugees and asylum seekers in South Africa (SA)¹⁰. It is difficult to gain accurate statistics on how many of them have been exposed to torture¹¹ or

7 Chennels op cit note 5; and also see Sarah op cit note 5; and also see Mitchell op cit note 5.

8 Ibid.

9 Ibid.

10 UNHCR 'South Africa' (2012), available at <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e485aa6>.

11 Art 1(1) of the United Nations Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (UNCAT) of 1985 defines torture as:

trauma, as they do not always report their experiences¹². However, a study conducted in 2006 by the Centre for the Study of Violence and Reconciliation in Johannesburg, estimated that approximately 35 000 refugees in SA have experienced torture¹³. When including those exposed to trauma, the number is likely far higher. Many of these refugees are exposed to traumatic experiences in their home country, along the journey and/or within SA¹⁴.

This high level of exposure to trauma has serious effects on the mental health of refugees¹⁵. Some studies suggest that around 60% of refugees suffer from a mental disorder.¹⁶ Furthermore, studies have shown that there is generally a higher rate of mental disorders amongst female refugees as compared to male refugees¹⁷. This may in part be because refugee women are more vulnerable to abuse and exploitation¹⁸ than their male counterparts.¹⁹ Despite this, Hathaway argues that female refugees' access to health care is an area which is often overlooked.²⁰

There is limited literature concerning refugees' access to mental health care services in SA²¹ and I have found none specifically addressing refugee women's access in Cape Town. However, the existing literature identifies that many refugees face barriers to accessing health care in general in SA²². Below I will provide a brief contextual background to this thesis question and in Chapter Two a more detailed review of existing

...[A]ny act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act which he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

12 International Rehabilitation Council for Torture Victims (IRCT) 'Asylum seekers, refugees and internally displaced persons' (2012), available at <http://www.irct.org/our-work/current-focus-areas/asylum-seekers-refugees-and-internally-displace-persons.aspx>.

13 Higson-Smith, C., Mulder, B. and Masitha, S. 'Human dignity has no nationality: A situational analysis of the health needs of exiled torture survivors living in Johannesburg, South Africa' (2006) *Unpublished research report by the Centre for the Study of Violence and Reconciliation: Johannesburg*, available at <http://www.csvr.org.za/docs/Humandignityhasnonationality.pdf>.

14 McColl et al op cit note 5; also see IRIN op cit note 5.

15 IRIN op cit note 5.

16 Ibid; also see Kinzie op cit note 6; also see also see Bhui op cit note 6; also see UCT Refugee Rights op cit note 6; also see Hollander et al op cit note 6.

17 Hollander et al op cit note 6.

18 Refugee women fall into two vulnerable societal groups – being female and being a refugee (Fuller, R. 'Double Jeopardy: women migrants and refugees in South Africa' (2008) 3 *Perspectives* 7-11.)

19 Robyn Leslie 'South Africa: promoting self-sufficiency among vulnerable refugee women' (8 April 2011), available at http://www.jrs.net/campaign_detail?PTN=PROMO-20100414073943&TN=PROJECT-20110407090619&L=EN.

20 James C. Hathaway 'The Rights of Refugees Physically Present: Access to Health Care' *The rights of refugees under international law* (2005).

21 J Vearey & L Nunez 'Towards improving forced migrant access to health and psychosocial rights in urban South Africa – a focus on Johannesburg' (2011), available at http://www.migration.org.za/sites/default/files/publications/2011/brief_8.pdf.

22 Ibid.

literature on the topic. I will start by addressing the refugee situation in the Cape and the trauma which has been faced by many female refugees there. I will then discuss what is known about the prevalence of mental disorders amongst these refugees and the gender-disparity in accessing mental health services. Following this I will expand on why this thesis question was chosen. Finally, I will discuss the necessity of such services for this population group.

3.1. High Numbers of Refugees in the Cape Metropole

Since the fall of Apartheid in 1994, many refugees from all over Africa have fled to SA²³. Most of these refugees come from the Democratic Republic of Congo (DRC), the Great Lakes region, the Horn of Africa and Zimbabwe²⁴, owing to instability in these regions²⁵. SA's liberal refugee policy and comparatively successful economy, in relation to other African states, are contributing to this high influx²⁶. From 2010 to 2011 SA received the most asylum applications globally²⁷.

The majority of the refugees arriving in SA settle in the cities of Johannesburg, Durban and Cape Town²⁸. While there is a dearth of statistics on refugees and asylum seekers in Cape Town, in 2001 it was estimated that approximately 4% of the population consisted of international migrants, including refugees and asylum seekers²⁹. In 2006 it was estimated that approximately 35 000 refugees were living in Cape Town³⁰. This number is probably far higher now with the ever-increasing number of refugees entering the country³¹.

23 L B Landau 'Urbanization, Nativism, and the Rule of Law in South Africa's 'Forbidden' Cities' (January 2005) *Working Paper Series on Research on Immigration and Integration in the Metropolis* available at <http://mbc.metropolis.net/assets/uploads/files/wp/2005/WP05-05.pdf>; also see Agnes Odhiambo 'A sick system abuses its refugees' *Human Rights Watch* (19 March 2012), available at <http://www.hrw.org/news/2012/03/18/sick-system-abuses-its-refugees>; also see Jonathan Crush 'South Africa: Policy in the face of Xenophobia' *Migration Information Source* (July 2008), available at <http://www.migrationinformation.org/Feature/display.cfm?ID=689>.

24 B Dodson 'Locating Xenophobia: Debate, Discourse, and Everyday Experience in Cape Town, South Africa' 56(3) *Africa Today*; also see UNHCR op cit note 10.

25 Parliamentary Monitoring Group (PMG) 'Role of United Nations Commissioner for Refugees (UNHCR) in South Africa on refugees: by UNHCR Regional Representative' (14 November 2011), available at <http://www.pmg.org.za/report/20111115-regional-representative-united-nations-commissioner-refugees-unhcr>.

26 SouthAfrica.info 'Refugees and Asylum Seekers' 29 October 2004, available at

http://www.southafrica.info/travel/documents/refugees_asylum.htm; also see Odhiambo op cit note 23.

27 UNHCR '2012 Regional Operations Profile – Africa' (2012), available at <http://www.unhcr.org/pages/4a02d7fd6.html>.

28 Landau op cit note 23.

29 UNHCR op cit note 10; also see M Mendelsohn 'The Clinical Challenge of Mental Health in South Africa' (2012) *Lecture for Division of Infectious Diseases and HIV Medicine, University of Cape Town*.

30 Penda op cit note 3.

31 Landau op cit note 23.

SA does not shelter refugees in camps; instead they are encouraged to integrate into local communities³². In Cape Town refugees live in diverse areas ranging from middle to upper income areas such as Central Cape Town and the Southern Suburbs to lower income areas such as the townships of Khayelitsha and Masiphumelele³³. However, most live in poorer socio-economic areas³⁴. These areas are characterised by high levels of violence and inadequate social service provision³⁵. The violence the refugees face is three-fold; first, they experience violence from other refugees; secondly, they are exposed to generalised violence and thirdly, they are often victims of xenophobic violence³⁶. This violence is often rooted in mistrust, competition for scarce resources and pressure on social services³⁷.

Many refugees are refused access to social services because of their status³⁸ and a number struggle to meet their basic needs such as food, shelter and water³⁹. In SA the onus is on refugees to integrate into local communities. Lack of resources, social networks and structural barriers, however, hinder their integration⁴⁰.

Refugees are often socially-isolated with decreased social support systems and networks⁴¹. Those in Cape Town often struggle to trust people and this hinders formation of new social networks⁴². There have been reports of agents from refugees' home countries coming to Cape Town, kidnapping refugees and taking them back to their home country⁴³. Fear of such agents adds to the general mistrust refugees have towards strangers⁴⁴. Furthermore, they often struggle to trust South Africans because of the xenophobic attacks they have experienced and they struggle to trust authority figures because of the

32 Vearey & Nunez op cit note 21; also see Consortium for Refugees and Migrants in South Africa (CoRMSA) 'Challenges to the successful implementation of policy to protect the right of access to health for all in South Africa' (3 June 2008) *Report to Dr Patrick Maduna Chief of Services: Gauteng Department of Health*, available at <http://cormsa.org.za/wp-content/uploads/Research/Access/MigrantGautengDoH.pdf>.

33 Dodson op cit note 24.

34 P Naicker 'To be a refugee in South Africa' (November 2000) *Track Two* 9(3), available at <http://www.queensu.ca/samp/sampresources/migrationdocuments/documents/2000/3.htm>; also see Vearey & Nunez op cit note 21.

35 Ibid.

36 Xenophobia has been defined as '...an intense fear or dislike of foreign people, their customs and culture'. D Breen & L Gwyther 'Refugees and other potentially vulnerable groups' (2009), in *Hospice Palliative Care Association of South Africa and Open Society Institute: Legal Aspects of Palliative Care*. Pinelands: HPCA at 86; also see Naicker op cit note 34.

37 Ibid; also see UNHCR op cit note 10.

38 Penda op cit note 3.

39 Mitchell op cit note 5.

40 Ibid.

41 Naicker op cit note 34.

42 Mitchell op cit note 5.

43 Ibid.

44 Ibid.

persecution many have experienced from authorities in the past⁴⁵. As a result of this mistrust and fear they frequently isolate themselves for protection⁴⁶

3.2. Exposure to Trauma amongst Female Refugees in the Cape

A large proportion of refugee women residing in Cape Town have experienced pre-migration, migration and post-migration trauma⁴⁷. An example of the first is that of Congolese women in Cape Town. Many have experienced severe torture, resulting in chronic physical and psychiatric conditions⁴⁸. Physical impairments can be a constant reminder of their torture experience. This makes it difficult for them to forget past traumas and exacerbates existing mental health disorders⁴⁹.

Others have been sexually assaulted while crossing the SA border and/or in SA⁵⁰. Not only is this sexual assault traumatic, but it can have multiple traumatic consequences⁵¹. Consequences include falling pregnant and contracting HIV/AIDS⁵². Those who fall pregnant may then be rejected by their husbands and families⁵³. A refugee counsellor in Cape Town said that while many of her female refugee clients had experienced multiple traumas prior to and during migration⁵⁴, experiences of sexual assault were highest after arrival in Cape Town⁵⁵. This high rate of post-migration trauma is reflective of the prevalence of violence in this city, with Cape Town being referred to as the ‘rape capital of the world’⁵⁶.

It has been reported that men with Post-Traumatic Stress Disorder⁵⁷ (PTSD) are more likely to be perpetrators of domestic violence⁵⁸. This has also been reported amongst

45 Ibid.

46 Ibid.

47 Chennels op cit note 5.

48 Ibid.

49 Morley, D, Glicken ‘Evidence Based Practice with Victims of Violence and Terrorism’ (21 June 2004) *Sage Publications*, available at

http://www.sagepub.com/upmdata/6070_Chapter_9__Glicken_Final_Pdf_3.pdf.

50 Ibid.

51 Ibid.

52 Ibid.

53 Ibid.

54 Sarah op cit note 5.

55 Ibid.

56 K Dey ‘Who is responsible for providing essential services to women?’ *NGO Pulse* 14 August 2012, available at <http://www.ngopulse.org/article/who-responsible-providing-essential-services-women>.

57 PTSD develops as a result of exposure to a single or multiple significant traumas. Symptoms include ‘intrusive recollections, avoidance behaviour, numbing, and hyper-arousal’. The persistence of symptoms and their effect on functioning are also diagnostic criteria for this disorder. (American Psychiatric Association ‘*Post Traumatic Stress Disorder*’ (2000) in *Diagnostic and statistical manual of mental disorder (Revised 4th ed.)*, available at <http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp>.)

58 N Mehraby ‘Refugee Women: The Authentic Heroines’ (2007) *NSW Service for Treatment and Rehabilitation of Torture and Trauma Survivors*, available at <http://www.startts.org.au/media/Research-Doc->

refugee women in Cape Town whose partners suffer from PTSD⁵⁹. Women from traditionally patriarchal societies may refrain from reporting domestic abuse as they perceive themselves as their husbands' possession⁶⁰. Lack of social support and networks outside the immediate family increases their reticence to report the violence.

3.3. High Prevalence of Mental Disorders amongst Refugees in the Cape

A high prevalence of psychiatric symptoms amongst female refugees in Cape Town has been noted by a number of individuals working with this group⁶¹. These psychiatric symptoms include anxiety, depression and PTSD symptoms and are likely linked to the multiple traumas they have experienced⁶². Many workers have described the complexity of the refugee trauma they observed⁶³.

While PTSD, Generalised Anxiety Disorders (GAD) and depression are the most common mental health disorders seen amongst refugees in Cape Town, there are also high rates of suicide, paranoid schizophrenia and substance misuse amongst this population⁶⁴. Even amongst those who do not have clinically-diagnosed psychiatric disorders, many are trying to cope with a profound sense of loss⁶⁵. They have lost their homes and often their families and friends⁶⁶. Furthermore, owing to xenophobic attacks many have repeatedly lost possessions and had to move numerous times while in Cape Town⁶⁷. The 'daily stressors' they face often exacerbate pre-existing conditions⁶⁸.

Counselling-Afghan-Survivors-of-TT.pdf, also see P Aspinall & C Watters 'Refugees and asylum Seekers: A review from an equality and human rights perspective' (2010) *Equality and Human Rights Commission Research Report Series*, University of Kent, available at http://www.equalityhumanrights.com/uploaded_files/research/refugees_and_asylum_seekers_research_report.pdf; also see Centre for Addiction and Mental Health (CAMH) 'Refugee Mental Health: Promising Practices and Partnership Building Resources' (2010), available at http://knowledgex.camh.net/amhspecialists/guidelines_materials/Documents/refugee_mental_health_prompractices.pdf.

59 Chennels op cit note 5.

60 Mehraby op cit note 58.

61 Chennels op cit note 5.

62 Ibid.

63 Ibid; also see Sarah op cit note 5; also see Mitchell op cit note 5.

64 Chennels op cit note 5; also see Mitchell op cit note 5; also see Anonymous (23 July 2012), personal communication (discussion); also see American Psychiatric Association 'Generalised Anxiety Disorders' (1983) *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* ed 3.

65 Mitchell op cit note 5.

66 Ibid.

67 Ibid.

68 Mitchell op cit note 5; also see Vearey & Nunez op cit note 21 at 7.

3.4. Higher Numbers of Male Refugees Compared to Female Refugees Accessing Services in the Cape

More than one refugee counsellor in Cape Town identified that there are more male than female refugees' accessing their services⁶⁹. At one refugee centre, female refugees rarely accessed the centre without their husbands visiting first⁷⁰. This gender-disparity in accessing services is not consistent with global gender patterns for accessing mental health care⁷¹. Globally, more females access psychiatric services than males⁷². However, gender differences in mental health care utilization differ between refugees from different cultural groups⁷³. As worldwide there is a higher prevalence of mental disorders amongst female compared to male refugees, this under-utilization of mental services by female refugees in Cape Town is troubling⁷⁴. It was proposed that this under-utilization could be due to numerous barriers⁷⁵. This study will seek to investigate the nature of these barriers.

4. Why are Mental Health Care Services for Traumatized Female Refugees a Pressing Need?

In addition to the immense personal suffering involved, trauma-induced mental illness negatively affects an individual's ability to function and survive in their context⁷⁶. This also has repercussions on their family, community and country.⁷⁷

'Through impeding optimal development and functioning, poor mental health impedes the development of people and the development of societies as a whole, trapping people in a cycle of poverty and [poor] mental health⁷⁸.'

69 Sarah op cit note 5; also see Mitchell op cit note 5.

70 Ibid.

71 S Saxena, G Thornicroft, M Knapp & H Whiteford 'Resources for mental health: scarcity, inequity, and inefficiency' (4 September 2007) 370(9590) *The Lancet*.

72 Ibid.

73 J Chun-Chung Chow, K D Jaffee & D Y Choi 'Use of Public Mental Health Services by Russian Refugees' (1999) 50(7) *Psychiatric Services*, available at <http://journals.psychiatryonline.org/article.aspx?articleid=83105>; also see B Guerin, P Guerin, R O Diiriye & S Yates 'Somali Conceptions and Expectations Concerning Mental Health: Some Guidelines for Mental Health Professionals' (2004) 33(2) *New Zealand Journal of Psychology*; also see Bhui op cit note 6; also see Sarah op cit note 5; also see Mitchell op cit note 5.

74 Hollander et al op cit note 6; also see Saxena et al op cit note 71.

75 Sarah op cit note 5.

76 K de Jong, S van der Kam, T Swarthout, N Ford, C Mills, O Yun, R J Kleber 'Exposure to Violence and PTSD symptoms amongst Somali women' (2011) 24(6) *Journal of Traumatic Stress* 628–634.

77 IRIN op cit note 5.

78 I Petersen 'At the heart of development: An introduction to mental health promotion and the prevention of mental disorders in scarce-resource contexts (2010) in *Promoting Mental Health in Scarce Resource Contexts: Emerging Evidence and Practice* (I Petersen, A Bhana, A J Flisher, L Swartz & L Richter eds.) Human Sciences Research Council at 7.

The disabling effects of poor mental health on functioning include difficulties in: holding down employment⁷⁹, engaging in self-care tasks, engaging in family and care-giver roles and difficulties in interacting socially⁸⁰. An employee at a refugee centre in Cape Town mentioned how the fear amongst her clients is often so disabling that they rarely venture from their homes⁸¹. Individuals with untreated psychiatric conditions often struggle to find stable employment and function in the workplace⁸². A recent study conducted on mental illness in SA indicated that increased state funding for psychiatric care, would lead to positive economic outcomes nationally and would decrease the ‘societal costs of mental illness’⁸³.

Refugee mothers are often the primary care-givers in their families. An Australian study found that amongst African refugees, women often took primary responsibility for providing for their families⁸⁴. Therefore, poor mental health of refugee mothers can be debilitating for their families⁸⁵. Inadequate treatment of primary victims of trauma can often result in secondary trauma for family members⁸⁶. Furthermore, women with trauma-related mental health conditions are at risk of abusing their children⁸⁷. In a study conducted amongst children in SA whose families had been exposed to trauma, findings showed that children were more affected by their mother’s reaction to trauma than by their own exposure to the trauma.⁸⁸

Psychiatric services can enable refugees to cope better with their situation⁸⁹. This in turn enables them to better integrate and actively engage in their context⁹⁰. Furthermore, intervention at the individual level, if effective, can positively impact the individual’s

79 IRIN op cit note 5.

80 W T Jeon, M Yoshioka & R F Mollica ‘Science of Refugee Mental Health: New Concepts and Methods’ (June 2001) *Centre for Mental Health Services*, available at <http://hpert-cambridge.org/wp-content/uploads/2011/01/ScienceofRefugeeMentalHealth.pdf>.

81 Chennels op cit note 5.

82 National Institute of Mental Health (NIMH) ‘Information about Mental Illness and the Brain’, available at <http://science.education.nih.gov/supplements/nih5/mental/guide/info-mental-c.htm>.

83 C, Lund., L, Myer., D, Stein., D, Williams. & A, Flisher ‘Mental illness and lost income amongst adult South Africans’ (2012) *Social Psychiatry and Psychiatric Epidemiology*, available at <http://www.ncbi.nlm.nih.gov/pubmed/23007296>.

84 D Costa ‘Health Care of Refugee Women’ (March 2007) 36(3) *Australian Family Physician*, available at http://www.peacewomen.org/assets/file/Resources/Academic/Health-Disp_HealthRefWomenVol36_AFP_Mar2007.pdf.

85 Ibid; also see IRCT op cit note 12.

86 Chennels op cit note 5.

87 Ibid.

88 D Edwards ‘Post-traumatic stress disorder as a public health concern in South Africa’ (2005) 15(2) *Journal of Psychology in Africa* 125–134, available at http://eprints.ru.ac.za/1471/1/Public_health_concern.pdf.

89 NIMH op cit note 82.

90 De Jong et al op cit note 76.

family and the broader community⁹¹. Lack of intervention, on the other hand, can have the opposite effect. It has been argued

‘[T]hat neglecting migrants[*sic*] mental and emotional wellbeing is a serious oversight that can not only hamper their chances of surviving and thriving in a new country, but is also likely to make them more dependent on host governments for longer⁹².’

Globally, there is a growing understanding of the importance of providing mental health care services for refugees rather than just providing for their physical needs⁹³. However, as physical needs such as the need for food and shelter are more obviously pressing, governments and NGOs tend to focus on meeting these needs but neglect to focus on psychological and psychiatric needs⁹⁴. Furthermore, there is often an unrealistic perception of refugees’ ability to cope with their past traumas⁹⁵. Mental distress experienced by traumatised refugees is seen to be a natural response to suffering which they will soon overcome⁹⁶. There is an assumption that owing to their resilience in surviving trauma and escaping to an asylum state they will be able to overcome these negative experiences and cope with the continuous stressors they face⁹⁷. However, there is growing evidence to refute this notion⁹⁸.

5. Access to Mental Health Services as a Basic Human Right

Access to mental health care is a basic human right. According to Article 25(1) of the Universal Declaration of Human Rights (UDHR): ‘Everyone has the right to...medical care....’⁹⁹. The Jakarta Declaration on Health Promotion into the 21st Century reiterates this fundamental right to health and calls for a greater focus to be placed on mental health needs¹⁰⁰. Furthermore, according to Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which SA has ratified, ‘...everyone has a right to the highest attainable standard of physical and *mental health*’ (emphasis

91 IRCT op cit note 12.

92 IRIN op cit note 5.

93 Jeon et al op cit note 80.

94 Mehraby op cit note 58; also see South African Federation for Mental Health (SAFMH) ‘SA Federation for Mental Health: Annual Report’ (April 2010 – March 2011), available at <http://www.safmh.org.za/Images/AnnRep11.pdf>.

95 Jeon et al op cit note 80.

96 Ibid.

97 Ibid.

98 Ibid.

99 Art 25(1) of the UDHR of 1948.

100 Para 8 of the Jakarta Declaration on Leading Health Promotion into the 21st Century of 1997.

added)¹⁰¹. SA has also ratified Resolution 61.7 of the 61st annual World Health Assembly (WHA) on the Health of Migrants of 2008¹⁰². This resolution requires ratifying states to promote access to health care for migrants in an equitable manner¹⁰³. Article 16 of the African Charter on Human and Peoples' Rights of 1981 identifies the right of everyone 'to enjoy the best attainable state of physical and *mental* health' (emphasis added). Furthermore, Article 2 of this Charter prohibits discrimination that negatively impacts on the enjoyment of these rights¹⁰⁴.

Section 27 of the South African Constitution identifies the right of 'everyone' to access health care¹⁰⁵. Section 27(a) of the South African Refugee Amendment Act No 33 of 2008 entitles refugees and asylum seekers to the enjoyment of the rights contained in the Constitution¹⁰⁶. It thus entitles them to equal access to health-care as citizens. Furthermore, while 'foreigners' are required to pay a user fee to access services, refugees and asylum seekers are not required to pay, if they cannot afford it¹⁰⁷. While female refugees living in Cape Town are legally entitled to public mental health care, this right is not always realised in practice¹⁰⁸. In this study I aim to explore the nature of the obstacles they face and the measures that can be taken to overcome them.

6. How this Study Aims to Address this Issue

This study aims to investigate the barriers to access to mental health care services faced by female refugees in the Cape Metropole through interviews with eight mental health care workers, who offer mental health care services within the Cape Metropole.

The study has been divided into six chapters. Chapter One provided an introduction through identification of the study problem and thesis question. It further provided a contextual background to the area of study and identifies the importance of the topic. Chapter Two discusses the relevant literature. Chapter Three details the Methodology used and the Ethical Principles applied. Chapter Four identifies and analyses study findings.

101 Art 12(1) of the ICESCR of 1966.

102 Naicker op cit note 34.

103 Ibid.

104 Art 2 of the African Charter on Human and Peoples' Rights of 1981.

105 Section 27 of The Constitution of the Republic of South Africa of 1996.

106'...[A] refugee is 'entitled to the same basic health services...that the inhabitants of the Republic receive from time to time' Section 27 (g) of the Refugees Act of South Africa of 1998.

107 Vearey & Nunez op cit note 21.

108 Mitchell op cit note 5; also see Chennels op cit note 5; also see Anonymous op cit note 64; also see K Anderson 'We'd go home if we could': political xenophobia, citizenship and human rights of asylum seekers and refugees : Cape Town--a pilot study' (2011) *Masters Dissertation* University of Cape Town.

Chapter Five involves a discussion of the findings and Chapter Six concludes the thesis and provides recommendation

CHAPTER TWO: LITERATURE REVIEW

SECTION 1 – REFUGEES AND MENTAL HEALTH

1. Introduction

In this literature review I will briefly address the prevalence and causes of trauma amongst refugees both internationally and in SA. I will then go on to focus on the barriers to mental health care treatment faced by refugees globally. I have referred to international literature, because there is limited literature on mental illness amongst, and psychiatric services for, refugees in SA. I will discuss the barriers to mental health care faced by many South Africans and the barriers to general health care faced by refugees in SA.

2. Refugees and Mental Health

At the end of 2011 there were an estimated 42.5 million ‘forcibly displaced’ individuals worldwide¹⁰⁹. Approximately 49% of them were females¹¹⁰. Traumatic experiences faced by a large proportion of refugees place them at high risk for mental illness¹¹¹. In 2006 there was an estimated 35 000 refugees in Cape Town.¹¹²

2.1. Prevalence of Mental Health Disorders amongst Refugees

2.1.1. Internationally

Studies have shown that there is a high prevalence of mental health disorders amongst refugees¹¹³. Some studies suggest that up to 60% of refugees suffer from some form of mental health disorder¹¹⁴. The most common mental disorders displayed by these populations are depression, anxiety disorders (including PTSD), psychosis¹¹⁵ and substance

109 UNHCR ‘UNHCR Global Trends 2011’, available at <http://www.unhcr.org/4fd6f87f9.html>.

110 Ibid.

111 Ibid.

112 UNHCR op cit note 10.

113 Kinzie op cit note 6; also see IRIN op cit note 5.

114 Kinzie op cit note 6.

115 Psychosis refers to ‘a disturbance in a person’s thinking that divorces them from their surrounding reality. This disturbance is often manifested in distorted perceptions (hallucinations), delusional (paranoid, grandiose and depressive) ideas, disorganised speech patterns, and intense mood fluctuations. These are...‘positive symptoms’ of psychosis. ‘[N]egative symptoms’ include[e] flattened emotions...loss of motivation...sleep disturbance, agitation and social withdrawal.’ (The Sainsbury Centre for Mental Health (SCMH) ‘A Window of Opportunity: A practical guide for developing early intervention in psychosis services’ (2003) at 15, available at http://www.centreformentalhealth.org.uk/pdfs/Window_of_Opportunity.pdf.)

misuse disorders¹¹⁶. Studies conducted on the mental health of refugees from Cambodia¹¹⁷, Vietnam¹¹⁸, Chile¹¹⁹, and Ethiopian immigrants to Israel, indicated that there were significantly high levels of depression and PTSD amongst these groups¹²⁰. This suggests that there are certain common factors experienced by refugees globally, which put them at risk for developing mental illness¹²¹. Even amongst those who do not have a clinically diagnosable disorder, many are grieving¹²².

What is the prognosis for refugees who do receive psychiatric care? Research on the mental health of Somali refugees in the United Kingdom indicated that there was a higher prevalence of anxiety, depression and psychotic symptoms amongst refugees who had recently arrived in the country, but suicidal ideation was more common in refugees who had been in the country for longer than seven years¹²³. Other research has shown that depression in refugees tends to decrease over time spent in an asylum state, while PTSD symptoms tend to remain¹²⁴. Findings from a Swedish¹²⁵ study indicated that there was no significant difference in use of psycho-tropic drugs amongst refugees depending on their length of stay in the country¹²⁶. Unfortunately, some refugees, despite receiving psychiatric treatment over a prolonged period, will continue to suffer psychiatric symptoms¹²⁷. The conditions in an asylum state can play a significant role in determining whether psychiatric symptoms will persist, be exacerbated or be reduced¹²⁸.

2.1.2. South Africa

The prevalence of mental disorders amongst the general population in SA is high, with about 16.5% of citizens suffering from some form of mental health disorder¹²⁹. The rate of mental illness amongst the migrant population in SA, which includes refugees, is even

116 Gorst- Unsworth (1992); Ramsay et al. (1993) & Health of Londoners Project (1999) in Kinzie op cit note 6; also see IRIN op cit note 5.

117 Carlson & Rosser-Hogan (1991); Cheung (1994); Kroll et al. (1989) in Kinzie op cit note 6.

118 Kinzie op cit note 6.

119 Thompson & McGorry (1995) in Kinzie op cit note 6.

120 Arieli & Aycheh (1992) in Kinzie op cit note 6.

121 Kinzie op cit note 6.

122 Mitchell op cit note 5.

123 Bhui op cit note 6.

124 Kinzie, Sack, Angell, Clarke, & Ben (1989); Sack et al. (1993) in Kinzie op cit note 6.

125 Hollander et al op cit note 6; also see Mitchell op cit note 5.

126 Hollander et al op cit note 6.

127 Kinzie op cit note 6; also see A Ager 'Responding to the Psychosocial needs of Refugees' *Forced Migration Online*, available at http://www.forcedmigration.org/rfgexp/pdfs/1_2.pdf.

128 T Sideris 'War, gender and culture – Mozambican women refugees' (2003) 56 *Social Science & Medicine* 713–724.

129 R Matzopoulos, J Corrigan & B Bowman 'A health impact assessment of international migrants following the xenophobic attacks in Gauteng and the Western Cape' (2009) *University of Witwatersrand Forced Migration Study Programme*; also see M Freeman, N Nkomo, Z Kafaar & K Kelly 'Mental disorder in people living with HIV/AIDS in South Africa' (2008) 38 *South African Journal of Psychology* 489–500.

higher than this¹³⁰. Trauma and xenophobia are two likely reasons for a higher rate of mental illness amongst this population group¹³¹. Unfortunately, these risk factors are on the rise in SA, as is illustrated in a report by Médecins Sans Frontières (MSF)¹³². Staff at an MSF Clinic in Musina have reported seeing a rise in trauma cases amongst refugees since the end of 2011¹³³.

2.2. Prevalence of Mental Health Disorders amongst Female Refugees

2.2.1. Internationally

Globally more women suffer from PTSD and depression than men and this gender difference is also reflected amongst refugees¹³⁴. Female refugees generally have higher rates of mental disorders than male refugees, owing to certain factors which make them more susceptible to these disorders¹³⁵. These mental disorders can range from less severe forms of anxiety and depression to severe PTSD and psychotic disorders¹³⁶.

A study conducted amongst refugee women in the Netherlands indicated that chronic psychiatric conditions were higher amongst female as compared to male refugees¹³⁷. Refugee women with lower levels of education and those living in poverty are at further risk¹³⁸.

In a study conducted on variations in mental health between males and females it was found that ‘genetic, biological factors and poor social support had much less effect than adverse experiences, roles and psychological attribute[s] on the dissimilarities between women and men¹³⁹’. Hollander et al (2011) argue that the nature of the trauma and stressors experienced by female refugees prior to migration and throughout the migration process could explain why more female refugees suffer from mental health disorders as compared to male refugees¹⁴⁰.

130 Matzopoulos et al op cit note 129; also see Freeman et al op cit note 129.

131 Ibid.

132 IRIN ‘SOUTH AFRICA: Asylum-seekers resort to border jumping’ 9 February 2012, available at <http://www.irinnews.org/Report/94820/SOUTH-AFRICA-Asylum-seekers-resort-to-border-jumping>.

133 Ibid.

134 Hollander et al op cit note 6; also see Saxena et al op cit note 71.

135 Hollander et al op cit note 6.

136 Mehraby op cit note 58.

137 AAM. Gerritsen, I Bramsen & W Devillé et al ‘Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands’ (2006) in 41(1) *Social Psychiatry and Psychiatric Epidemiology* 18-26, available at <http://www.springerlink.com/content/p2596r8751738705/>.

138 Saxena et al op cit note 71.

139 Hollander et al op cit note 6.

140 Ibid.

2.2.2. South Africa

There are no accurate statistics on the prevalence of mental health disorders amongst female refugees in SA or the Western Cape. However, in consultation with refugee counsellors in Cape Town it emerged that a number of female refugees they came into contact with, suffered from PTSD, generalised anxiety disorders and depression¹⁴¹. Furthermore, many of them had experienced sexual violence and as a result suffered from shame, poor self-esteem and guilt¹⁴².

3. Risk Factors for Development of Mental Health Disorders amongst Refugees

Numerous risk factors make refugees particularly vulnerable to psychiatric illness¹⁴³. Difference in levels and frequency of trauma experienced pre-migration, during migration and post-migration have an effect on acquisition and exacerbation of mental disorders¹⁴⁴. Multiple traumatic experiences put refugees at a greater risk¹⁴⁵. While not all refugees have experienced trauma, a large proportion of them have¹⁴⁶. Factors such as level of education, previous work experience, culture, gender, and conditions within the asylum state, also affect the likelihood of mental disorders¹⁴⁷.

141 Chennels op cit note 5; also see Mitchell op cit note 5; also see Sarah op cit note 5.

142 Lauren Wolfe 'Eight reasons why victim blaming needs to stop: Writers, activists and survivors speak out' *Women's Media Centre: Women Under Siege* 17 December 2012, available at <http://www.womenundersiegeproject.org/blog/entry/eight-reasons-why-victim-blaming-needs-to-stop-writers-activists-and-survivors>; also see Rape Crisis Cape Town Trust 'Rape Trauma Syndrome', available at <http://rapecrisis.org.za/information-for-survivors/rape-trauma-syndrome/>.

143 Saxena et al op cit note 71; also see Kinzie op cit note 6.

144 Lavik et al in Bhui op cit note 6; also see Kinzie op cit note 6; also see Gerritsen et al op cit note 137.

145 Jeon et al op cit note 80.

146 Kinzie op cit note 6; also see United Nations Action against Sexual Violence in Conflict 'Mental health and psychosocial support for conflict-related sexual violence: principles and interventions' (November 2011) *Report of Meeting of WHO, UNFPA & UNICEF* in Ferney-Voltaire, France; available at http://apps.who.int/iris/bitstream/10665/75179/1/WHO_RHR_HRP_12.18_eng.pdf.

147 Lavik et al in Bhui op cit note 6; also see Kinzie op cit note 6.

3.1. Pre-Migration Risk Factors

Pre-migration risk factors refer to some of the traumas experienced by refugees prior to their flight, which can lead to mental illness¹⁴⁸.

3.1.1. Internationally

3.1.1.1. Physical and Psychological Trauma

Many refugees have multiple experiences of trauma. This trauma may be physical¹⁴⁹, psychological¹⁵⁰ or a combination of both. Traumatic experiences can include persecution, torture, near death experiences, injuries, disease and conflict¹⁵¹. Substance misuse to cope with the trauma can also be a risk factor¹⁵². Exposure to or experience of violence, particularly in conflict regions, is another major risk factor¹⁵³. During conflict social norms and values are often shattered, such as when a child is forced to rape his mother¹⁵⁴. Such experiences are incredibly destructive for an individual's worldview and can shatter their sense of self¹⁵⁵. In a study conducted with political detainees in Vietnam, experience of torture was highly correlated with depression and PTSD amongst participants¹⁵⁶. Other pre-migration stressors, such as food, water and shelter deprivation, also place refugees at a greater risk of suffering from anxiety and depression¹⁵⁷.

148 Ager op cit note 127.

149 Physical trauma may be defined as 'a serious bodily injury or shock, as from violence or an accident' (The American Heritage Stedman's Medical Dictionary 'Trauma' (2002) *Dictionary.com website*, available at <http://dictionary.reference.com/browse/Trauma>.)

150 Psychological trauma may be defined as 'an emotional wound or shock that creates substantial lasting damage to one's psychological development, often leading to neurosis (*sic*)'. (The American Heritage Stedman's Medical Dictionary 'Trauma' (2002) *Dictionary.com website*, available at <http://dictionary.reference.com/browse/Trauma>.)

151 UCT Refugee Rights op cit note 6.

152 In a study conducted on risk factors for development of mental health symptoms amongst adult, Somali refugees in the UK; a pre-migration risk factor for developing psychiatric symptoms, was Somali refugees' use of a drug called Qat. This drug is a stimulant and there was a correlation between Somali refugees who were users, and those who displayed psychiatric symptoms (Kinzie op cit note 6.)

153 Bhui op cit note 6.

154 Sideris op cit note 128.

155 Ibid.

156 Kinzie op cit note 6.

157 Ibid.

3.1.1.2. Loss

Forced migration is an incredibly stressful and traumatic experience often leaving individuals with a profound sense of loss¹⁵⁸. This loss includes: loss of family members and friends, loss of homes, possessions and loss of livelihoods¹⁵⁹. Further losses include: loss of language, cultural values, social identity and sense of belonging¹⁶⁰. The loss of culture and social belonging are often the most difficult losses to deal with¹⁶¹. Even those who have found asylum in a relatively safe place may suffer chronic psychiatric symptoms from this loss¹⁶².

3.1.1.3. Secondary Trauma

Secondary Trauma can be defined as ‘the stress resulting from helping or wanting to help a traumatised or suffering person¹⁶³’. Even if refugees have not experienced the trauma themselves, observation or knowledge that those around them are victims of trauma can be very distressing¹⁶⁴. Furthermore, many may suffer secondary trauma from trying to comfort their friends and family who have also experienced trauma. This is exacerbated when the individual, offering support, has also experienced trauma.

3.1.2. Pre-Migration Risk Factors Specific to Female Refugees

A major pre-migration risk factor faced by female refugees is experience of gender-based violence. Violence against women is defined by the Declaration on Elimination of Violence against Women (DEVAW) of 1993 as:

...[A]ny act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life¹⁶⁵.

158 IRIN op cit note 5; also see Sideris op cit note 128.

159 UCT Refugee Rights op cit note 6.

160 Sideris op cit note 128.

161 Ibid.

162 IRIN op cit note 5; also see Kinzie op cit note 6.

163 D Conrad ‘Secondary Trauma’ (2010), available at <http://secondarytrauma.org/>.

164 UCT Refugee Rights op cit note 6; also see Sarah op cit note 5.

165 Art 1 of DEVAW of 1993.

DEVAW identifies refugee women and women in times of conflict as being particularly vulnerable to violence¹⁶⁶. Owing to sexual violence having multiple repercussions it is often used against women in conflict settings as a means to oppress, humiliate and traumatise¹⁶⁷. According to the UNHCR, approximately 80% of female refugees have been raped or sexually abused¹⁶⁸. This gender-based violence can lead to physical deformities and disabilities, HIV/AIDS, Sexually Transmitted Infections (STIs) and pregnancy¹⁶⁹. It also has multiple psychological repercussions for women¹⁷⁰. In addition to anxiety and depression, women who have been victims of gender-based violence may suffer from anorexia; somatic complaints (unrelated to their physical trauma); decreased self-esteem and experience relationship difficulties¹⁷¹.

3.2. Migration Risk Factors

There are numerous experiences which refugees face during the migratory process which places them at risk for mental illness. The nature of the flight, the country which the individual is fleeing from and the asylum state they are going to all affect the level of trauma they may experience during flight.

3.2.1. Internationally

The flight process can be very traumatic for a number of reasons¹⁷². Traumatic experiences include: struggling to meet basic needs; travelling extensive distances; experiences of violence¹⁷³; separation from family members¹⁷⁴ and fear for the future¹⁷⁵. A study conducted with African and Latin-American Refugees in Canada indicated how separation from family members during the asylum process placed refugees at risk for developing a psychiatric condition¹⁷⁶.

166 Preamble to DEVAW of 1993.

167 Matzopoulos et al op cit note 129.

168 Mehraby op cit note 58.

169 Ibid; also see Costa op cit note 84.

170 Costa op cit note 84.

171 Ibid.

172 Kinzie op cit note 6.

173 Ager op cit note 127.

174 Kinzie op cit note 6.

175 Ager op cit note 127.

176 Rousseau, Mekki-Berrada, & Moreau (2001) in Kinzie op cit note 6.

3.2.2. South Africa

Many refugees coming to SA, especially those who enter illegally, have traumatic experiences whilst crossing the SA border¹⁷⁷. Since 2011, the SA Department of Home Affairs has made it increasingly difficult for refugees to seek asylum¹⁷⁸. As a result, there has been a growing number of refugees who have sought to enter the country illegally¹⁷⁹. Illegal entry increases their chances of being exposed to trauma¹⁸⁰. Gangs along the SA border who are referred to as the ‘Guma-guma’, rob, rape and abuse many refugees who enter illegally¹⁸¹. Owing to their illegal status, many refugees who have been victims of atrocities committed by these gangs never report to the police for fear of being deported. Members of these gangs, therefore, remain un-thwarted in their violent endeavours¹⁸². Starvation, drowning and attacks from wild animals are further threats to refugees during the migration process¹⁸³. A security guard on a farm along the SA border reported how he daily came across refugees from Somalia, Congo, Rwanda and Zimbabwe who were seeking to enter the country illegally¹⁸⁴. He discussed the condition he finds many of them in:

‘Most are in a bad state. A week ago we found four people dead; maybe they got lost in the bush and died from hunger and exhaustion¹⁸⁵.’

Fear of authorities prevents many of those attacked or injured while crossing the border from seeking health care. Most are primarily focused on getting a refugee permit and even if they are in great need of health care they will not risk seeking assistance, as they fear it could impede their chances of getting a permit and could possibly result in their deportation¹⁸⁶.

177 IRIN op cit note 132.

178 Ibid.

179 Ibid; also see CoRMSA ‘Protecting Refugees, Asylum Seekers and Immigrants in South Africa during 2010’ (April 2011) *CoRMSA Report*, available at <http://www.cormsa.org.za/wp-content/uploads/2011/07/CoRMSA-Report-20111.pdf>; also see Darshan Vigneswaran ‘A Foot in the Door: Access to Asylum in South Africa’ (August 2008) 40 *Migration Studies Working Paper Series*, available at http://cormsa.org.za/wp-content/uploads/Research/Asylum/40_AFootInTheDoor.pdf.

180 IRIN op cit note 132.

181 Ibid; also see Doctors Without Borders also see ‘Refugees and Asylum Seekers in South Africa’ *Briefing Document*, available at <http://www.doctorswithoutborders.org/publications/article.cfm?id=4465&cat=briefing-documents>.

182 IRIN op cit note 132.

183 Ibid; also see Chennels op cit note 5.

184 IRIN op cit note 132.

185 Ibid.

186 Ibid.

3.2.3. Migration Risk Factors Specific to Females

The migration process has been shown to have different effects on women as compared to men¹⁸⁷. Gender-differences have been noted in both the types and consequences of trauma faced by refugees during the migration process¹⁸⁸. As soon as women seek to leave their country they are at high risk of violence, particularly sexual violence¹⁸⁹. At border areas women often face exploitation by officials and roving gangs¹⁹⁰. Furthermore, female refugees who are mothers bear the additional stress of caring for their children throughout the migration process. Refugee mothers, who travel without a partner, often face an overwhelming level of stress in seeking to provide for the material and psychological needs of their children while also seeking to ensure their safety¹⁹¹.

3.3. Post-Migration Risk Factors

Post-migration risk factors are to a degree dependant on the asylum state. However, there are certain common risk factors which refugees face in most asylum states.

3.3.1. Internationally

Post-migration risk factors have been linked to the development of psychiatric symptoms amongst refugees¹⁹². However, it can be difficult to distinguish between whether pre-migration, migration or post-migration stressors are primarily responsible for these symptoms¹⁹³. Often symptoms are as a result of compounded trauma. Refugees are extremely vulnerable to further stressful experiences, particularly if these are violent such as xenophobic attacks¹⁹⁴, or harsh treatment by government officials and conditions in detention centres¹⁹⁵. Even after they have integrated into host countries, inequality, unemployment and poor socio-economic conditions are risk factors for poor mental health¹⁹⁶. A further risk factor is when asylum states differ greatly from refugees' home countries, as this makes assimilation harder¹⁹⁷. Separation from family members, fear for

187 Sideris op cit note 128.

188 Breen & Gwyther op cit note 36.

189 Ager op cit note 127; also see Mehraby op cit note 58.

190 Breen & Gwyther op cit note 36.

191 Matzopoulos et al op cit note 129; also see Kinzie op cit note 6.

192 Kinzie op cit note 6.

193 Hollander et al op cit note 6.

194 Kinzie op cit note 6.

195 Ibid.

196 Saxena et al op cit note 71.

197 Kinzie op cit note 6.

family members left in their home country, homesickness and inadequate social support are further risk factors¹⁹⁸.

Post-migration risk factors with regards to documentation and legal status differ between asylum seekers and refugees¹⁹⁹. Legal risk factors include: illegal entry into the country, prolonged waiting for refugee status determination, fear of deportation and barriers to accessing work or social services²⁰⁰. Research conducted amongst Tamil asylum seekers and refugees showed that there are higher levels of anxiety and depression amongst asylum seekers as compared to refugees owing to the above-mentioned factors²⁰¹. This finding has been reiterated in other studies²⁰².

3.3.2. South Africa

The violence experienced by many refugees in SA is to a degree symptomatic of the high levels of societal violence in this country²⁰³. This violence exacerbates the multiple traumas they have already experienced²⁰⁴.

Asylum seekers in SA generally have to wait for prolonged periods of time for status determination, and many refugees and asylum seekers live with the fear that they will be deported²⁰⁵. Living in this space of uncertainty is often extremely anxiety-provoking²⁰⁶. Added fears include refugees' experience of xenophobia and discrimination both by officials and lay South Africans²⁰⁷. The continuous nature and pervasiveness of this xenophobic abuse is illustrated in a quote from a participant in a study on the experience of refugees during the xenophobic violence of 2008:

198 Kinzie op cit note 6; also see Gerritsen et al op cit note 137; also see R Schweitzer, F Melville & Z Steel et al 'Trauma, Post-Migration Living Difficulties, and Social Support as Predictors of Psychological Adjustment in Resettled Sudanese Refugees' (2006) 40(2) *Australian and New Zealand Journal of Psychiatry* 179-187.

199 C Watters 'Emerging Paradigms in the Mental Health Care of Refugees' (2001) 52 *Social Science & Medicine* 1709-1718; also see D Silove, Z Steel & P McGorry et al 'Trauma exposure, post-migration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum-seekers: comparison with refugees and immigrants' (1998) 97(3) *Acta Psychiatrica Scandinavica* 175-81.

200 Ibid; also see Kinzie op cit note 6.

201 Watters op cit note 199; also see Silove et al op cit note 199.

202 Samuel Law, Miles Hutton & Diana Chan 'Clinical, Social, and Service Use Characteristics of Fuzhounese Undocumented Immigrant Patients' (2003) 54(7) *Psychiatric Services*, available at <http://journals.psychiatryonline.org.ezproxy.uct.ac.za/article.aspx?articleid=180641>.

203 Matzopoulos et al op cit note 129.

204 IRIN op cit note 5.

205 The Legal Resources Centre (LRC) 'Refugees', available at <http://www.lrc.org.za/refugees>.

206 Ibid.

207 Ibid.

‘We are disconnected. We are abused, verbally and physically, in trains and in buses and in taxis²⁰⁸.’

The psychological effects of xenophobia on refugees in SA are multiple. They include: feelings of loneliness; loss of hope, identity and sense of belonging; as well as a constant sense of vulnerability; embarrassment, humiliation, depression and anxiety²⁰⁹.

People with psychiatric conditions often face social exclusion in their communities. When one considers that refugees in SA are already discriminated against, one can only imagine how a refugee with a psychiatric condition is stigmatised and excluded²¹⁰.

3.3.3. Post-Migration Risk Factors Specific to Female Refugees

3.3.3.1. Internationally

Post-migration risk factors particularly relevant to female refugees include: vulnerability to gender-based violence²¹¹ (including domestic violence)²¹²; multiple stressors related to lack of documentation²¹³; economic vulnerability²¹⁴ and difficulties associated with child-rearing in unfamiliar and uncertain contexts²¹⁵. Lack of social networks is a particular risk factor for refugee women²¹⁶. Many female refugees, from more traditional cultures, are left within the home where they are responsible for caring for the family and performing domestic chores²¹⁷. This increases their isolation as they have few opportunities to build new social networks²¹⁸.

In the Netherlands, studies identified that refugee women were affected more than men through the asylum application process, and this had a significant effect on their mental well-being²¹⁹.

208 L Vromans, R D Schweitzer, K Knoetze & A Kagee ‘The Experience of Xenophobia in South Africa’ *The Community* p.2.

209 Ibid.

210 WHO ‘WHO Quality Rights Toolkit: Assessing and improving quality and human rights in mental health and social care facilities’ (2012), available at

http://whqlibdoc.who.int/publications/2012/9789241548410_eng.pdf.

211 G.A. Del Prado ‘The United Nations and the promotion and protection of the rights of women: How well has the organization fulfilled its responsibility’ (1995) 2(51) *William & Mary Journal of Women and the Law* at 69.

212 Sideris op cit note 128.

213 Del Prado op cit note 211.

214 Sideris op cit note 128.

215 Ibid; also see Mehraby op cit note 58.

216 Sideris op cit note 128.

217 Mehraby op cit note 58.

218 Ibid.

219 Hollander et al op cit note 6.

3.3.3.2. South Africa

Violence against migrants/refugees and violence against women are two forms of violence that are viewed with horror by the general public and outside world but are, in fact, normalised ways in which South African society interacts with minority and vulnerable groups. The double jeopardy that faces refugee and migrant women is just that: they are at the intersection of these two groups that are so vulnerable to exploitation, abuse and violence²²⁰.

Female refugees in SA encounter numerous challenges including²²¹ sexual exploitation²²² and xenophobic violence. They are more vulnerable than men to xenophobic violence²²³. In 2008 during widespread xenophobic attacks, many refugee women were raped²²⁴. The psychological consequences of rape include: humiliation; shame, guilt and loss of dignity; decreased self-esteem and confidence; sense of powerlessness; flashbacks and nightmares; and depression and anxiety²²⁵. As a result of the high level of sexual violence amongst refugee women in SA some of them may fall pregnant and develop STDs and/ or HIV/ AIDs²²⁶. Owing to various cultural factors refugee women who are raped in SA often face stigma, and are blamed for their traumatic experience. A number of these refugee women are then ostracised from their husbands, families and communities. An example of this was reported at a refugee centre in Cape Town. A young refugee girl was raped and fell pregnant. As a result her family ordered her to leave the home as she was seen to bring shame on the family. Ostracised refugee women lack a supportive social network and this diminishes their ability to cope with their trauma²²⁷.

Further post-migration risk factors experienced by female refugees in SA include: difficulty finding work especially for those with children²²⁸; stress of ensuring both their survival and the survival of their children (if mothers)²²⁹; lack of documentation which makes them more vulnerable to gender-based violence (as they are less likely to report an

220 Fuller op cit note 18.

221 Ibid; also see Silove et al op cit note 199; also see Matzopoulos et al op cit note 129.

222 Silove et al op cit note 199; also see Matzopoulos et al op cit note 129; also see Leslie op cit note 19.

223 Silove et al op cit note 199; also see Matzopoulos et al op cit note 129.

224 Ibid.

225 Mehraby op cit note 58.

226 Silove et al op cit note 199; also see Matzopoulos et al op cit note 129.

227 Sideris op cit note 128.

228 Breen & Gwyther op cit note 36.

229 Refugee mothers in SA often face difficulties in finding low-cost accommodation that will accept children and they also tend to earn less than those without children (Breen & Gwyther op cit note 36.)

offence or seek assistance if they are undocumented)²³⁰; lack of support and loneliness due to limited social connections²³¹.

230 Ibid.

231 Sideris op cit note 128.

SECTION 2: BARRIERS TO ACCESS TO MENTAL HEALTH CARE FOR REFUGEES

1. Introduction

The following section reviews the literature which is central to providing a background to my thesis question. First, I will provide a background to Mental Health Care in SA. I will identify the relevant policy documents and will then describe the state of Mental Health Care in the Western Cape. Following this, I will outline the main barriers to mental health services faced by refugees internationally and compare this with barriers faced by refugees in SA. As there is very limited literature on refugees' access to mental health care in SA, I will also include general barriers to health care faced by these refugees.

2. Mental Health Care in South Africa

The Minister of Health, Dr A Motsoaledi stated in an address at the National Mental Health Summit held in April 2012, that: '...the prevalence of mental disorders in our country is high and...vulnerability and associated risk factors are increasing²³²'.

The third most common health condition in SA is neuropsychiatric disorders²³³. However, owing to lack of funding for mental health care, only approximately 28% of individuals in SA with mental disorders have access to treatment²³⁴. There is therefore a huge lack in service provision to citizens and refugees²³⁵. This situation is not unique to SA. In many developing countries, mental healthcare is not prioritised and as a result psychiatric services are under-resourced and insufficient²³⁶. Refugees in SA accessing mental health services are accessing under-resourced and over-burdened systems²³⁷.

232 Department of Health 'Speech as delivered by the Minister of Health: Dr AP Motsoaledi' at the *National Mental Health Summit* 12-13 April 2012.

233 Vearey & Nunez op cit note 21; also see R Norman, D Bradshaw & M Schneider et al 'Revised Burden of Disease Estimates for the Comparative Risk Factor Assessment, South Africa' (2006) *South African Medical Research Council: Burden of Disease Research Unit*, available at <http://www.mrc.ac.za/bod/RevisedBurdenofDiseaseEstimates1.pdf>; also see Mental Health and Poverty Project (MHPP) 'Policy brief 2: The prioritisation of mental health as a public health issue in South Africa' (November 2008), available at http://www.who.int/mental_health/policy/development/MHPB2.pdf

234 Burns in Vearey & Nunez op cit note 21; also see C Lund, S Kleintjes & R Kakuma et al 'Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications' (2010) 45 *Social Psychiatry Epidemiology* 393-404.

235 Burns in Vearey & Nunez op cit note 21; also see WHO 'Who-Aims Report on Mental Health System in South Africa' (September 2007) *WHO and Department of Psychiatry and Mental Health, University of Cape Town*, available at http://www.who.int/mental_health/evidence/south_africa_who_aims_report.pdf.

236 Petersen et al op cit note 78; also see Lund et al op cit note 234.

237 Vearey & Nunez op cit note 21; also see K Dadey *Refugee Health: A Gender Comparison in Health Care Access* (unpublished MA, Ryerson University, 2008) 90.

Despite this, the government has allowed refugees with severe mental health conditions to access disability grants²³⁸. However, such grants are not available to asylum seekers – this is a big problem for asylum seekers with mental health conditions who have to wait for prolonged periods for status determination²³⁹.

The South African policy guidelines concerning mental health are found in: the White Paper for the Transformation of the Health System in South Africa of 1997; the National Health Policy Guidelines for Improved Mental Health in South Africa of 1997 and the Mental Health Care Act of 2002²⁴⁰. However, there is still no comprehensive national mental health policy plan²⁴¹.

2.1. White Paper for the Transformation of the Health System in South Africa of 1997

The White Paper for the Transformation of the Health System in South Africa of 1997 focuses on decentralisation of health services and development of a district health system²⁴². The paper contains implementation strategies for Mental Health Care at a National Level²⁴³. One of these strategies is ensuring equity in mental health service provision²⁴⁴. The paper also stresses that ‘all mental health staff’ need to be trained in working with clients with PTSD and victims of violence²⁴⁵. In the preamble this policy document only refers to health care for ‘citizens’, hereby excluding refugees and contradicting constitutional provisions and the SA Refugee Act of 1998²⁴⁶. Furthermore, there has been insufficient implementation of the strategies contained within this policy document. Most of the mental health budget is allocated to psychiatric hospitals while limited funding and treatment is offered in the primary care setting²⁴⁷.

238 Chennels op cit note 5.

239 Ibid.

240 Vearey & Nunez op cit note 21.

241 WHO op cit note 235.

242 WHO ‘WHO Country Cooperation Strategy: South Africa’ (2008-2013), available at http://www.who.int/countryfocus/cooperation_strategy/ccs_zaf_en.pdf.

243 MHPP op cit note 233.

244 Department of Health (DOH) *White Paper for the Transformation of the Health System in South Africa* (April 1997), available at <http://www.info.gov.za/whitepapers/1997/health.htm#Chapter 12>.

245 Ibid.

246 Ibid.

247 Ibid; also see J K Burns ‘The Mental Health Gap in South Africa – A Human Rights Issue’ (2011) 6 *The Equal Rights Review*, available at http://www.escri-net.org/usr_doc/Mental_Health_Gap_-_South_Africa.pdf.

2.2. National Health Policy Guidelines for Improved Mental Health in South Africa of 1997

The National Health Policy Guidelines for Improved Mental Health in South Africa of 1997 should be read in conjunction with the White Paper for the Transformation of the Health System in South Africa of 1997²⁴⁸. It focuses on decentralising mental health services from large mental institutions to primary health care²⁴⁹ (PHC) facilities²⁵⁰. It also involves clients and their families; advocates human rights promotion and protection of users and calls for equitable mental health provision across different sectors of the population²⁵¹. Unfortunately, this policy has not been officially published or effectively implemented and is not considered official policy²⁵². Nevertheless, it has still influenced opinion and practice in the mental health sector.

2.3. Mental Health Care Act of 2002

The Mental Health Care Act of 2002 is one of the most progressive Mental Health Care Acts globally, even including a section dedicated to the rights of those with mental disabilities living in institutional facilities²⁵³. However, there exists a gap between legislation and implementation²⁵⁴. While mental health provision has been prioritised in the National Health Policy, it is not prioritised in practice²⁵⁵. Lack of funding has resulted in inadequate implementation and therefore inadequate mental health provision remains a major public health concern in SA²⁵⁶.

248 MHPP op cit note 233; also see Edwige Faydi, Michelle Funk & Sharon Kleintjes et al 'An assessment of mental health policy in Ghana, South Africa, Uganda and Zambia' (2011) 9 *Health Research Policy and Systems*, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3090369/>.

249 Primary Health Care is defined by WHO as essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination (University of Saskatchewan, College of Medicine 'Definition of Primary Health Care' (2011), available at <http://www.medicine.usask.ca/research/health-research-groups/primary-health-care-research-group-1/definition-of-primary-health-care/index.html>.)

250 WHO op cit note 235.

251 Ibid; also see MHPP op cit note 233.

252 Vearey & Nunez op cit note 21; also see MHPP op cit note 233; also see Crick Lund, Sharon Kleintjes & Victoria Campbell-Hall et al 'Mental health policy development and implementation in South Africa: a situation analysis - Phase 1. Country Report' (31 January 2008) *Mental Health and Poverty Project*, available at http://www.who.int/mental_health/policy/development/SA%20Country%20Report%20-%20Final%20Draft%20Jan%202008.pdf; also see WHO op cit note 235; also see Faydie et al op cit note 248.

253 Lund et al (2010) op cit note 234; also see Lund et al (31 January 2008) op cit note 252.

254 Vearey & Nunez op cit note 21.

255 Lund et al op cit note 234.

256 Vearey & Nunez op cit note 21.

3. Mental Health Care in the Western Cape

In the Western Cape there are 455 outpatient clinics, four child and adolescent outpatient clinics, two day centres, six psychiatric inpatient units, nine residential community facilities and four psychiatric hospitals²⁵⁷. There is a higher referral rate from general practitioners to mental health providers in the Western Cape than in any other province, apart from Johannesburg²⁵⁸. There is a significant difference in Western Cape Primary Health Clinics, between those which have doctors and those without²⁵⁹. Most clinics (over 80%) without doctors have assessment and treatment protocols for mental health conditions²⁶⁰. Interestingly, very few clinics (below 20%) with doctors have such protocols²⁶¹. Out of all the provinces, the Western Cape has the highest number of psychiatrists (0.9 per 100 000), general practitioners (1.4 per 100 000), social workers (0.6 per 100 000) and psychiatric occupational therapists (0.5 per 100 000)²⁶². The number of psychiatrists is a third of the international requirement and this is particularly problematic given the high prevalence of psychiatric conditions in this province²⁶³. The number of mental health nurses is 10.5 per 100 000 and psychologists is 0.7 per 100 000²⁶⁴. This is lower than in some other provinces. In general there has been an overall decline in mental health providers in SA since the 1990s²⁶⁵. The mental health budget is provincially allocated²⁶⁶ and in most provinces, including the Western Cape²⁶⁷, is integrated into the provincial health budget. At present there are no statistics on the percentage of the Western Cape health budget which is allocated to psychiatric services²⁶⁸.

4. Barriers to Mental Health Services Faced by Refugees

Accessibility of Mental Health Care incorporates the following four dimensions: it must be physically accessible; it must be economically accessible (affordable); there must be non-discrimination in provision of services; and there must be informational accessibility

257 Lund et al op cit note 234; also see Western Cape Government 'Mental Health Hospital Services' (2013) *DOH*, available at http://www.westerncape.gov.za/eng/your_gov/305/services/11505/6447.

258 Lund et al op cit note 234.

259 Ibid.

260 Ibid.

261 Ibid.

262 Ibid.

263 Vearey & Nunez op cit note 21.

264 Lund et al op cit note 234.

265 Ibid.

266 WHO op cit note 235.

267 Ibid; also see Western Cape Government 'Department of Health Western Cape Budget 2012' (2012)

DOH, available at http://www.westerncape.gov.za/other/2012/3/vote_06__infra.pdf; also see WHO op cit note 235.

268 Ibid.

(individuals must have an understanding of their right to health care and knowledge of where they can access services)²⁶⁹. When discussing the barriers I will look at which of these four dimensions have not been realised as well as looking at additional barriers which affect accessibility.

4.1. Barriers to Mental Health Services Faced by Refugees Internationally

Use of mental health services can be inhibited by both demand and supply²⁷⁰. Approximately 75% of individuals with mental health problems in low to middle income countries face barriers to mental health services²⁷¹. Internationally, there is generally a lower rate of utilization of psychiatric services amongst refugees, despite the higher prevalence of mental health conditions amongst them²⁷². Internationally the following have been recorded as barriers for refugees: cultural and social barriers; resource constraints and service fees; lack of knowledge concerning right to services; discrimination in provision of services; language barriers, lack of documentation and mistrust. Furthermore, the mental condition itself can pose a barrier²⁷³. Symptoms such as anxiety and avolition can hinder individuals from seeking help²⁷⁴.

4.2. Barriers to Health Care for Refugees in South Africa

Officially in SA, refugees have the right to mental health care²⁷⁵. Even if a refugee or asylum seeker lacks necessary documentation, they still have the right to access public health services²⁷⁶. However, this right is not always granted in practice²⁷⁷. Unfortunately, many refugees still face barriers to health care including mental health care²⁷⁸. In a study conducted in Johannesburg in 2011, on forced migrants' access to health services, participants faced specific barriers to mental health services as a result of their refugee/

269 N Huls 'Access to Health' *Review Digest: Human Rights & Health*, available at <http://www.du.edu/korbel/hrhw/researchdigest/health/access.pdf>.

270 Saxena et al op cit note 71.

271 WHO 'WHO Mental Health Gap Action Programme (mhGAP)' (2012), available at http://www.who.int/mental_health/mhgap/en/index.html.

272 Kinzie op cit note 6.

273 IRIN op cit note 5.

274 Ibid.

275 Breen & Gwyther op cit note 36.

276 Ibid.

277 Guerin et al op cit note 73.

278 Breen & Gwyther op cit note 36; also see South African Human Rights Commission (SAHRC) 'Public Inquiry: Access to Health Care Services' (2009), available at <http://www.info.gov.za/view/DownloadFileAction?id=99769>; also see Vearey & Nunez op cit note 21.

asylum status²⁷⁹. The primary barriers they faced were language barriers, problems associated with lack of documentation and xenophobic or discriminatory attitudes from staff at health institutions²⁸⁰.

4.3. Cultural and Social Barriers

4.3.1. Internationally

4.3.1.1. Stigma

In certain countries, stigma about mental health disorders results in less funding being allocated to psychiatric services²⁸¹. This stigma tends to be higher in lower income countries²⁸². It can also be a barrier to refugees with psychiatric symptoms, as they often feel ashamed at having a mental illness and fear the rejection and discrimination they may experience if they seek assistance²⁸³. This was found in a study conducted on traumatised female refugees from South America²⁸⁴.

4.3.1.2. Culture and Religion

‘The subjective meaning of mood states, abnormal ideation, and the inability to fulfil normal social roles or to have a meaningful existence are all culturally bound²⁸⁵.’

Cultural²⁸⁶ and religious characteristics of refugee populations can influence whether these refugees recognise psychiatric symptoms and how they deal with these symptoms²⁸⁷.

279 Ibid.

280 Ibid.

281 Saxena et al op cit note 71.

282 Ibid.

283 Ibid.

284 Estella Rosa Irias Giroin, Antonia Ponce Marroquin & Helene Berman et al ‘A Narrative Study of Refugee Women Who Have Experienced Violence in the Context of War’ (March 2005) *Centre for Research on Violence Against Women and Children*, available at http://www.crvawc.ca/documents/RefugeeWomenReport_Mar05_withCover.pdf

285 Karen L. Peifer, Teh-wei Hu & William Vega ‘Help Seeking by Persons of Mexican Origin With Functional Impairments’ (2000) 51 *Psychiatric Services*10, available at <http://journals.psychiatryonline.org.ezproxy.uct.ac.za/article.aspx?articleid=85025>

286 Culture can be defined as ... ‘[T]he behaviours, values and beliefs shared by a group of people, such as an ethnic, racial, geographical, religious, gender, class or age group’ (University of Pennsylvania Collaborative on Community Integration ‘Cultural Competence in Mental Health’, available at http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/community_inclusion/Cultural_Competence_in_MH.pdf.)

287 Hollander et al op cit note 6; also see Peifer et al op cit note 285.

Different cultures and religions have different perceptions of what mental illness entails and this makes diagnosis and treatment of mental illness amongst different cultural groups, complex²⁸⁸. Cultural and religious factors which lead to under-utilisation of mental health services include: failure to recognise psychiatric symptoms²⁸⁹; visiting traditional healers when there is a health problem; reliance on religious leaders and certain religious beliefs about mental health disorders and the use of psychiatric services²⁹⁰.

There is often an under-reporting of psychiatric symptoms amongst refugees, as many consider these symptoms an inevitable part of everyday life²⁹¹. Amongst many Somali refugees, mental health symptoms are only viewed as a disorder in extreme cases²⁹².

4.3.2. South Africa

4.3.2.1. Stigma

In SA there are high rates of discrimination against and stigma associated with individuals with mental illness²⁹³. Many South Africans view mental illness as a sign of weakness with 78.79% believing that it is unnecessary to seek professional assistance if one has a mental illness²⁹⁴. Refugees from certain groups fear being stigmatised and ostracised from their family and community if they seek psychiatric treatment²⁹⁵. Amongst mental health providers there may be a stigma towards refugees' accessing services, because of their refugee status. This was noted in a study conducted on refugees' accessing psychiatric services in Johannesburg²⁹⁶.

4.3.2.2. Culture and Religion

In SA, there is a diverse array of cultures, religions and beliefs²⁹⁷. These influence people's perceptions of mental illness and how it should be treated²⁹⁸. Certain groups uphold more

288 Jeon et al op cit note 80.

289 Hollander et al op cit note 6.

290 Saxena et al op cit note 71.

291 Bhui op cit note 6.

292 Guerin et al op cit note 73.

293 WHO op cit note 210; also see Saxena et al op cit note 71.

294 Saxena et al op cit note 71.

295 IRIN 'HEALTH: Addressing mental illness stigma in Somali diaspora' 25 July 2011, available at <http://www.irinnews.org/Report/93319/HEALTH-Addressing-mental-illness-stigma-in-Somali-diaspora>.

296 Vearey & Nunez op cit note 21.

297 John Cantius Mubangizi 'A South African Perspective on the Clash between Culture and Human Rights, with Particular Reference to Gender-Related Cultural Practices and Traditions' (2012) 13(3) *Journal of International Woman's Studies*, available at http://www.bridgew.edu/soas/jiws/Vol13_no3/3_JohnS.pdf.

universally agreed-upon understanding of mental illness, while others hold to more culture-bound norms of mental illness and treatment²⁹⁹. A large proportion of the South African population visit traditional healers for mental health complaints³⁰⁰. Religious leaders are also often consulted prior to or in place of a mental health practitioner³⁰¹. Consultation with traditional and religious leaders can be beneficial for less severe mental illnesses, but for moderate to severe mental disturbances it can end up being a barrier to vital treatment³⁰². There are also refugees from various cultural backgrounds and religious beliefs in Cape Town, and their access to mental health services could be affected by their differing perceptions of mental illness. In this study I hope to determine whether there is a difference in service utilization between female refugees from certain cultural or religious groups and then determine what aspects of their cultural or belief system pose a barrier.

4.4. Resource Constraints and Service Fees

4.4.1. Internationally

In low to middle-income countries underfunding of mental health services, and insufficient staff present a major barrier to provision of psychiatric services³⁰³. High cost of psychotropic medication and service fees are further barriers³⁰⁴. While governments in higher income countries tend to allocate more of their health budget to mental health care, the allocation is still generally insufficient to meet the need³⁰⁵.

298 Department of Health 'Policy Guidelines on Child and Adolescent Mental Health', available at <http://www.info.gov.za/view/DownloadFileAction?id=94167>.

299 R.W. Cheetham & A Rzakowolski 'Crosscultural psychiatry and the concept of mental illness' (1980) 58(8) *South African Medical Journal* 320 -325; available at <http://www.ncbi.nlm.nih.gov/pubmed/7404245>.

300 T Zabow 'Traditional healers and mental health in South Africa' (2007) 4(4) *International Psychiatry*, available at <http://www.rcpsych.ac.uk/pdf/IPv4n4.pdf#page=5>.

301 K Sorsdahl, D.J. Stein & A .J. Flisher 'Traditional Healer Attitudes and Beliefs Regarding Referral of the Mentally Ill to Western Doctors in South Africa' (2010) 47 *Transcultural Psychiatry* 591-609, available at <http://tps.sagepub.com.ezproxy.uct.ac.za/content/47/4/591>.

302 Ibid.

303 Saxena et al op cit note 71.

304 Ibid.

305 S Saxena, P Sharan & B Saraceno 'Budget and Financing of Mental Health Services: Baseline Information on 89 Countries from WHO's Project Atlas' (2003) 6 *The Journal of Mental Health Policy and Economics* 135-143, available at http://www.icmpe.org/test1/journal/issues/v6pdf/6-135_text.pdf.

4.4.2. South Africa

In SA there is confusion by staff at health facilities, as well as by refugees themselves, regarding service fees and how much different classes of foreigners are required to pay³⁰⁶. It has been reported that staff at health centres have sometimes overcharged refugees owing to lack of understanding of when and how much to charge them³⁰⁷. Some staff are reported to have denied refugees access altogether³⁰⁸. Their reasoning is that they have a tight budget and citizens must be prioritised³⁰⁹. Indigent refugees are reticent about accessing health services because they do not feel that they will be able to afford them³¹⁰. However, asylum seekers and refugees who present with their permits are legally entitled to services at the same costs as South Africans of the same economic bracket³¹¹. Mental health services at NGOs are generally free³¹². Unfortunately, the cost of transport to health facilities can also present a barrier³¹³.

Governments and funders often focus on meeting refugees' immediate 'tangible' needs and because psycho-social needs are not as obvious, funding mental health programmes is not always seen as a priority³¹⁴. A narrow focus which neglects to consider funding the psychosocial needs of refugees, fails to address the long term consequences that unmet psychosocial needs have both on individuals concerned and the larger society³¹⁵. Owing to the recent global economic crisis, there has been a decrease in international donor funding for many centres providing trauma counselling for refugees³¹⁶. This has resulted in retrenchment of staff at a number of these centres, and hence these organizations have a decreased organizational capacity to meet refugees' mental health needs³¹⁷.

306 Breen & Gwyther op cit note 36.

307 Ibid.

308 Medecins Sans Frontieres (MSF) 'No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa' (2 June 2009) *Special Report*, available at <http://www.doctorswithoutborders.org/publications/article.cfm?id=3646>.

309 Breen & Gwyther op cit note 36.

310 Ibid.

311 CTRC 'Health Services' (2008), available at <http://www.ctrc.co.za/upload/Health%20Services.pdf>.

312 Ibid.

313 Lund et al op cit note 234.

314 IRIN op cit note 5.

315 Ibid.

316 R Davis 'The Great NGO Funding Crisis' *Daily Maverick* 23 July 2012, available at <http://dailymaverick.co.za/article/2012-07-23-the-great-ngo-funding-crisis>.

317 Ibid; also see IRIN op cit note 5; Sarah op cit note 5.

4.5. Lack of Knowledge of Rights

4.5.1. Internationally

In a study conducted in New Zealand amongst Somali refugees, their lack of knowledge about their right to health care posed a barrier³¹⁸. This appears to be a common barrier, even in first world countries.

4.5.2. South Africa

‘In South Africa, refugees in principle enjoy the right to access healthcare, but “many refugees are finding a vast chasm between theory and practice...³¹⁹’

A study conducted with asylum seekers in Gauteng indicated that many refugees in SA are unaware of their right to health care. As a result, few refugees submit complaints when their rights are impinged on³²⁰. There is also a lack of understanding by many health care providers in SA on the rights of refugees³²¹. This has resulted in their denying access to many refugees³²². Unfortunately, there is not a consistent understanding of the laws and policies applicable to this population group³²³. This ‘inconsistent application of relevant laws and policies’ with regards to provision of health services to refugees was reiterated by the South African Human Rights Commission (SAHRC) in June 2007³²⁴.

4.6. Discrimination and Xenophobia from Service Providers

4.6.1. Internationally

Refugees are sometimes subject to discriminatory treatment by service providers³²⁵. Even in first world countries they can experience discrimination on the basis of socio-economic

318 Guerin et al op cit note 73.

319 K Magardie 'We don't treat foreigners' *Mail and Guardian* 25 September 2000, available at <http://www.queensu.ca/samp/sampresources/migrationdocuments/commentaries/2000/foreigne.htm>.

320 SAHRC op cit note 278.

321 Breen & Gwyther op cit note 36.

322 Ibid; also see Magardie op cit note 319.

323 SAHRC op cit note 278.

324 Breen & Gwyther op cit note 36.

325 Jonathan Crush & Godfrey Tawodzera 'Medical Xenophobia: Zimbabwean Access to Health Services in South Africa' (2011) 54 *The Southern African Migration Programme: Migration Policy Series*, available at <http://dSPACE.cigilibrary.org/jspui/bitstream/123456789/31582/1/SAMP-%20Medical%20Xenophobia.pdf?1>; also see Julie Ilondo 'Xenophobia at public hospitals' *Women24 7*

factors or owing to their minority group membership³²⁶. Research in the United Kingdom identified that Somali women were often subject to discriminatory treatment by health workers, based on stereotypes and racist attitudes held by these workers³²⁷. Discrimination is a major risk factor for psychiatric disorders amongst refugees. Discrimination by health providers may exacerbate their symptoms and make them reticent to access services³²⁸.

4.6.2. South Africa

Barriers to health services in SA are often found at the individual and institutional level³²⁹. There is not a blanket discrimination towards refugees across health institutions but rather staff at some institutions are discriminatory³³⁰. Research in Gauteng indicated that refugees felt that the xenophobic attitudes of service providers posed a major barrier to their ability to enjoy their right to health care³³¹. This barrier was reiterated with regards to mental health care, in a study conducted with forced migrants in Johannesburg³³².

It appears that there is a greater prevalence of xenophobic attitudes amongst health clerks and nurses, who have been reported as turning refugees away³³³. They often argue that they are conserving limited health resources for citizens³³⁴. However, their actions violate the SA Refugee Act which acknowledges that refugees should have equal access to health care as citizens³³⁵. Discriminatory attitudes towards refugees are much lower amongst doctors³³⁶.

In Cape Town it is reported that more female as compared to male refugees face xenophobic attitudes when accessing general health services³³⁷. These attitudes are more prevalent in the outlying areas of Cape Town and in densely populated townships such as Nyanga and Khayelitsha³³⁸. It could be possible that these attitudes are also prevalent amongst mental health providers³³⁹.

December 2011, available at <http://www.women24.com/Wellness/BodyAndSpirit/Xenophobia-at-public-hospitals-20111207>; also see Aspinall & Watters op cit note 58.

326 Aspinall & Watters op cit note 58; also see Law et al op cit note 202.

327 Aspinall & Watters op cit note 58.

328 Ibid; also see Ilondo op cit note 325.

329 Breen & Gwyther op cit note 36.

330 Ibid; also see Independent Online (IOL) 'Xenophobia, red tape hurts refugees' 20 June 2003, available at <http://www.queensu.ca/samp/ImmigrationBillComments/Regulations/ImmReg.htm>.

331 SAHRC op cit note 278.

332 Vearey & Nunez op cit note 21.

333 Breen & Gwyther op cit note 36.

334 Ibid.

335 Ibid.

336 Ibid.

337 Anonymous op cit note 64.

338 Ibid.

339 Ibid.

4.7. Language Barriers

4.7.1. Internationally

Language can pose a significant barrier to access³⁴⁰. It can pose a barrier in terms of: knowledge about where to access services; making an appointment; filling out necessary paper work³⁴¹ and in treatment. Communication is an essential part of psychiatric treatment and the subtleties of what is expressed can greatly aid in diagnosis and treatment³⁴². Lack of proficiency in the native tongue of a host state can hamper access and effectiveness of psychiatric treatment³⁴³. In the study conducted with Somali refugees in New Zealand, they found that miscommunication and problems with translation limited the efficacy of treatment³⁴⁴. While translators can be helpful, they are not always available³⁴⁵. Use of translators can impinge on client confidentiality, and clients may be less willing to share honestly with a service provider if a translator is involved³⁴⁶. Finally, the quality of translation can be poor and this can negatively affect treatment outcomes³⁴⁷.

4.7.2. South Africa

Refugees in SA face similar language barriers to refugees in other parts of the world³⁴⁸. Lack of translators or poor translation can lead to miscommunication and lack of understanding of the health issues at stake³⁴⁹. Mental Health Care in the Western Cape is already under-resourced and provision of translators at public health services is often not seen to be feasible.

340 L Harben 'An Interdisciplinary Approach to Refugee Mental Health during the Acculturation Process' *Unpublished Paper for Georgia College and State University* available at http://hercules.gcsu.edu/~doetter/lib_stud/pubs/harben_0812.pdf; also see M. D. Morris, S. T. Popper, T. C. Rodwell, S. K. Brodine & K. C. Brouwer 'Healthcare Barriers of Refugees Post-Resettlement' (2009) 34 *Journal of Community Health* 6 at p. 529–538; available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2778771/pdf/10900_2009_Article_9175.pdf; also see Unite for Sight 'Module 9: Health and Patient Barriers to Care for Resettled Refugees' (2011), available at <http://www.uniteforsight.org/refugee-health/module9>.

341 Morris et al op cit note 340.

342 P Smith 'Culture, Language and Mental Health' (October 2010) *Lectures for Occupational Therapy Students* University of Cape Town Department of Psychiatry and Mental Health.

343 Harben op cit note 340.

344 Guerin et al op cit note 73.

345 B. Heidi Ellis, Alisa B. Miller & Heather Baldwin et al 'New Directions in Refugee Youth Mental Health Services: Overcoming Barriers to Engagement' (2011) 4(4) *Journal of Child & Adolescent Trauma* 69–85.

346 Smith op cit note 342.

347 Morris et al op cit note 340.

348 Hathaway op cit note 20.

349 Guerin et al op cit note 73; also see Breen & Gwyther op cit note 36.

4.8. Lack of Documentation

4.8.1. Internationally

Resolution 1.4 of March 2012 of the World Health Assembly, on Barriers to Accessing Refugee Health Services, identifies how lack of documentation can hamper access³⁵⁰. In some countries undocumented refugees are not allowed to access public services and are referred to NGOs. For others, lack of documentation hinders them from seeking access, as they fear there may be repercussions, such as deportation³⁵¹. Lack of documentation has been linked to poorer mental health prognosis³⁵². While NGOs are a great asset in provision of health services to refugees, governments should not use their existence as an excuse to neglect their state obligations. States which have ratified the UN Convention Relating to the Status of Refugees are obliged to provide health services to refugees regardless of their documentation status³⁵³.

4.8.2. South Africa

Lack of documentation is also a major barrier in SA³⁵⁴. Many asylum seekers without necessary documentation are barred from accessing health services³⁵⁵. This was a problem for forced migrants seeking mental health care in Johannesburg³⁵⁶. Lack of documentation is often a result of Department of Home Affairs delaying documentation processing³⁵⁷. Undocumented asylum seekers often fear accessing health services³⁵⁸, but they are entitled to do so even without the necessary documentation³⁵⁹.

350 Montreal World Health Organization Simulation '2012 Charter on Refugee Health: Barriers to Accessing Refugee Health Services' (2012), available at <http://www.monwho.org/about-monwho/archives/charter-on-refugee-health/barriers-to-accessing-refugee-health-services/>.

351 Law et al op cit note 202.

352 Ibid.

353 Breen & Gwyther op cit note 36.

354 Ibid.

355 SAHRC op cit note 278.

356 Vearey & Nunez op cit note 21.

357 SAHRC op cit note 278.

358 Breen & Gwyther op cit note 36; also see IRIN op cit note 132.

359 IOL op cit note 330; also see Breen & Gwyther op cit note 36.

4.9. Mistrust

4.9.1. Internationally

Mistrust and fear amongst refugees can be a barrier to open, in-depth discussion with them in the mental health setting³⁶⁰. This can hinder history-taking and diagnosis of the client³⁶¹. The client may fear that what they say and how they behave may affect how they are treated and may have consequences for their stay in the asylum state³⁶². Mistrust will vary between refugee communities, and can be influenced by their pre and post-migration experiences as well as by their diagnosis³⁶³. Lack of respect and professionalism by service providers increases mistrust³⁶⁴. The perception that the health provider lacks understanding of conditions and cultural factors in the refugee's home country can make refugees suspicious of the provider's competence and increase mistrust³⁶⁵.

4.9.2. South Africa

Mistrust can make refugees in the Cape fearful to talk freely³⁶⁶. The presence of agents in SA further hampers some clients from opening up³⁶⁷. This is particularly challenging in the mental health sector as in order to effectively counsel someone, the service provider needs a basic understanding of the client's history³⁶⁸. Furthermore, probing questions which are necessary could evoke suspicion and fear in clients. Some clients also prefer counselling sessions not to be recorded as they fear agents could access the documented files³⁶⁹. This is a further challenge for health providers as documenting clients is a necessary part of effective service provision³⁷⁰. Another difficulty is to distinguish between legitimate

360 Willis & Gonzalez (1998) in Jeon et al op cit note 80; also see Ellis et al op cit note 345.

361 Willis & Gonzalez (1998) in Jeon et al op cit note 80.

362 Ibid; also see P Peterson, D Sackey, I Correa-Velez, M Kay 'Building trust: Delivering health care to newly arrived refugees' (2010) *Mater Health Services Brisbane Limited*, available at http://www.materonline.org.au/getattachment/Services/Refugee/Clinical-Resources-and-Publications/Building-trust_-Delivering-health-care-to-newly-ar.pdf.

363 Ibid.

364 Ibid.

365 Ibid.

366 Two participants mentioned how this was particularly the case with Rwandan refugees in the Cape (Mitchell op cit note 5; also see Sarah op cit note 5.)

367 Sarah op cit note 5; also see M Bandeira, C Higson-Smith, M Bantjes & P Polatin 'The land of milk and honey: a picture of refugee torture survivors presenting for treatment in a South African trauma centre' (2010) 20(2) *Torture : quarterly journal on rehabilitation of torture victims and prevention of torture* 92-103.

368 Fred Rossi 'Documentation in Counselling' *Darebin Community Health*, available at <http://www.vha.org.au/uploads/FredRossi.pdf>.

369 Sarah op cit note 5.

370 Fred Rossi op cit note 368.

paranoia and paranoia as a symptom of the client's disorder³⁷¹. While mistrust is an issue for many refugees globally, it is compounded in SA as a result of xenophobia, discrimination and the presence of agents³⁷².

4.10. Barriers Specific to Female Refugees

4.10.1. Internationally

Hathaway argues that as a group, refugee women's specific health needs are often overlooked³⁷³. Not only is this detrimental to refugee women, but it also has repercussions for a female refugee's family, particularly if the refugee is a mother³⁷⁴. Refugee mothers often hold the family together and their illness can incapacitate their family³⁷⁵.

The study conducted amongst Somali women in the UK, showed that more male refugees visited psychiatric services as compared to female refugees³⁷⁶. However, an equal number of females as compared to males visited general practitioners³⁷⁷. In this study it appeared that women often sought treatment for somatic complaints, when they had underlying mental health disorders³⁷⁸. This has been noted in a number of studies on female refugees and mental health³⁷⁹. Somatization is particularly prevalent amongst female refugees from cultures which prohibit the display of emotions³⁸⁰.

4.10.2. South Africa

It is likely that barriers to accessing mental health services experienced by female refugees globally would be similar to those experienced in Cape Town. Yet, some barriers may be unique to Cape Town. This study aimed to gain a clearer understanding of the multiple obstacles facing female refugees in Cape Town. The next chapter outlines the methodology that was used to determine this.

371 Sarah op cit note 5; also see Chennels op cit note 5.

372 Sarah op cit note 5.

373 Hathaway op cit note 20.

374 G Camus-Jacques 'Refugee Women: The Forgotten Majority' (1989) 141 (142) *Refugees and International Relations* in G Loescher & L Monahan eds.

375 Ibid.

376 Bhui op cit note 6.

377 Ibid.

378 Ibid.

379 Sideris op cit note 128; also see Bhui op cit note 6; also see Mehraby op cit note 58.

380 Ibid.

CHAPTER THREE: METHODOLOGY

1. Introduction

This chapter discusses the methodology of this study. It describes the study design and the ethical principles applied. It further describes how the aim and objectives were achieved. The aim of this study was to answer my thesis question:

What are the barriers to access to mental healthcare services in the Cape Metropole, faced by refugee women who have been exposed to trauma?

The objectives of this study were to identify the right of female refugees to access public mental health services and determine the government policies relating to the promotion and protection of this right. The objectives further sought to determine whether and to what extent this right is being upheld and promoted and the areas in which this right is hampered. The final objective was to determine whether female refugees face barriers to accessing public mental health care services, and if barriers existed to identify the nature of them.

2. Study Design

A qualitative study design and phenomenological approach were used. The rationale for using this design was manifold. First, the data which the study aimed to collect was qualitative rather than statistical; therefore a qualitative design was more appropriate³⁸¹. Qualitative techniques allowed for in-depth exploration of the study phenomenon from the perspective of participants³⁸². Secondly, I intended to gain an understanding of the commonalities between the lived experiences of the participants³⁸³. This approach allowed for this and provided comprehensive findings³⁸⁴. This contextual approach provided a greater understanding of the many factors³⁸⁵, including social, cultural and structural

381 Natasha Mack, Cynthia Woodsong & Kathleen M. MacQueen et al ‘*Qualitative Research Methods: A Data Collector’s Field Guide*’ (2012) Family Health International, available at http://www.fhi360.org/en/RH/Pubs/booksReports/QRM_datacoll.htm.

382 Norman, K. Denzin & Yvonna, S. Lincoln ‘*Strategies of Qualitative Inquiry*’ (2005) SAGE Publications.

383 John W. Creswell ‘*Qualitative Inquiry and Research Design – Choosing among five different approaches*’ (2007) SAGE Publications.

384 Ibid.

385 Ibid.

factors, which informed the behaviour of female refugees³⁸⁶. Thirdly, this study design was chosen as it was seen to be socially sensitive.

3. Study Approach

A phenomenological approach was chosen for a number of reasons. It enabled me to describe what was common amongst participants' experiences and perceptions of the phenomenon being studied³⁸⁷. In this study the phenomenon was '*the barriers to accessing mental health services faced by female refugees in the Cape Metropole who have been exposed to trauma*'. This approach enabled me to gain an understanding of 'what' were commonly perceived as barriers by participants³⁸⁸. By uncovering shared perceptions of these barriers and solutions to overcoming them, I sought to outline the main areas to address in order to improve access for this population group.

4. Data Collection Methods

Initially I had planned to collect data in two ways. First, I aimed to collect it through semi-structured in-depth interviews with eight mental health care workers at four different organizations. Secondly, following these interviews, I aimed to run a focus group with all these participants. The interviews were conducted but the focus group was not run, as through the study process it emerged that it would not be feasible owing to time-constraints. All the participants that I interviewed were under extreme time pressure, with a number of them being the only mental health providers in their facility. Furthermore, the time allocated for interviews was sufficient to ensure data saturation without needing to conduct the focus group³⁸⁹.

4.1. Semi-structured In-depth Interviews

Semi-structured, in-depth interviews were chosen for data gathering, as this method allowed for comprehensive, in-depth analysis of the mental health care workers'

386 Ibid.

387 Victor Daniels 'Lecture Notes: Phenomenology' (September 2005) *Sonoma State University*, available at <http://www.sonoma.edu/users/d/daniels/phenomlect.html>

388 John W. Cresswell (1998) in T. Groenweld 'A Phenomenological Research Design Illustrated' (2004) 3(1) *International Journal of Qualitative Methods*.

389 J.M. Morse (1994) in M. Mason 'Sample Size and Saturation in PhD Studies Using Qualitative Interviews' (2012) 11(3) *Forum: Qualitative Social Research*, available at <http://nbn-resolving.de/urn:nbn:de:0114-fqs100387>; also see Cresswell op cit note 388.

experiences and perceptions of the phenomenon being investigated³⁹⁰. This method also provided a degree of flexibility and as a result did not limit or dictate the type of data collected³⁹¹. Though flexible, the questions had some structure in order that the data collected sufficiently answered the study question³⁹².

Initially, I set-out to conduct in-depth interviews with eight mental health care workers from four institutions. However, through contacting various clinics and NGOs throughout Cape Town it emerged that many of these institutions only have one counsellor. As a result I altered my study method by increasing the sample from four organizations to six organizations (one of the organizations had more than one counsellor and thus I conducted two interviews there).

One interview was conducted with each participant. Each interview lasted approximately 60 minutes. Morse (1994) argues that six or more interviews are sufficient for a phenomenological study.³⁹³ According to Creswell (1998) no more than ten interviews are required for a phenomenological study³⁹⁴. Thus the number and length of my interviews were appropriate for my study method.

Interviews were recorded using a sound recorder and were then transcribed. Participants completed informed consent forms prior to the interviews to consent to the interviewing and recording. All participants consented to being recorded. After transcribing the interviews I conducted member checking³⁹⁵ to ensure that I had correctly interpreted what the participants had said. Member checking occurred via email.

5. Gaining Access

When exploring the validity of my thesis question, I established contact with a number of organizations and individuals who offer mental health services to refugees. Most of the individuals and organizations I contacted said that they would be willing to be interviewed if I decided to do an empirical study. Therefore, I first re-connected with these organizations after my study method was finalised. Both public facilities and NGOs I

390 Mack et al op cit note 381.

391 Ibid.

392 Ibid.

393 Morse op cit note 389.

394 Creswell op cit note 388.

395 'Member Validation also called member check... is a procedure largely associated with qualitative research, whereby a researcher submits materials relevant to an investigation for checking by the people who were the source of those materials.' M, S. Lewis – Beck., A. Bryman & T. Futing-Lao 'The SAGE Encyclopaedia of Social Science Research Methods (2012), available at <http://www.srmo.sagepub.com/view/the-sage-encyclopedia-of-social-science-research-methods/n548.xml>.

396 Laerd dissertation 'Purposive Sampling: An overview' (2010), available at <http://dissertation.laerd.com/articles/purposive-sampling-an-overview.php>.

contacted were under extreme time constraints. However, NGOs were generally more willing to engage in the study. The public health facilities were harder to contact and I contacted numerous of these facilities without success, before finding willing participants. A number of the public health facilities I contacted either did not offer mental health services or were reticent to participate as they said they saw few refugee clients. There was a common consensus amongst public health facilities that they saw relatively few mental health clients who were refugees. This was particularly the case at the primary care level.

When negotiating access with organizations, I first asked their permission to interview mental-health workers in their organization. Following this, I asked the organizations if they would prefer to remain anonymous in the report.

6. Population and Sampling

I interviewed seven mental health care workers from six institutions as well as a private counsellor. I decided to interview mental-health providers rather than refugee clients for a number of reasons. These reasons included:

- Many refugees in the Cape are not first language English speaking, and this language barrier would have complicated the interviewing process;
- Owing to their experiences, many of the refugees in SA are very suspicious and find it difficult to trust people and thus if I did interview them they may have felt threatened and been unwilling to share their stories;
- Many of these refugees' experiences are traumatic and I felt that it would be unethical to conduct a study with them as it could lead to emotional distress. As I am not a counsellor this sharing could be distressing rather than therapeutic for them.
- Furthermore, through interviewing counsellors who collectively have worked with many refugees, I hoped to gain a more comprehensive answer to my thesis question.

I asked organizational representatives to identify one or two of their mental health care workers whom I could interview. Purposive expert sampling was used to select participants, in other words participants were chosen because of their knowledge and experience of the phenomenon³⁹⁶.

396 Laerd dissertation 'Purposive Sampling: An overview' (2010), available at <http://dissertation.laerd.com/articles/purposive-sampling-an-overview.php>.

Criteria for selection of participants included:

- That they were mental health care workers or counsellors;
- That they had worked or had contact with female refugees who have been exposed to trauma;
- That they had worked in an NGO which offers mental health care services, or with a public mental health service in the Cape Metropole for at least 6 months;
- and that they spoke English.

The sample size and number of interviews I conducted provided me with a broad understanding of the phenomenon. I interviewed three participants from two non-governmental organizations (NGOs) and one participant who is a renowned refugee trauma counsellor, who though in private practice does pro-bono counselling of refugees. I also interviewed four mental health workers, working at four public health facilities in the Cape. Two of these public health facilities were primary health clinics and two were hospitals. I chose to interview counsellors from both NGOs and public health facilities as refugees access services at both types of facilities in the Cape Metropole³⁹⁷. This also helped to diversify my sample and to provide a more comprehensive perspective on perceived barriers. I sought to determine whether perceived barriers differed between participants working at NGOs and those at public health facilities. I hoped that this variety in gatekeepers and participants would provide me with a better realization of the barriers caused by the facilities themselves and what were commonly perceived barriers within the refugee communities.

7. Gaining Consent from Participants

After the study process was explained to participants and each had been provided with an information sheet, they completed the informed consent sheet. I ensured that they understood that they were not obliged to participate in the study and that they were free to drop out of the study at any time (this information was included on the informed consent forms). I also ensured that all participants were legally competent and therefore free to decide whether or not they wanted to participate in the study.

397 Chennels op cit note 5; also see Sarah op cit note 5; also see Mitchell op cit note 5.

8. Ethical Considerations

Ethics approval for this study was granted by the UCT Law Faculty Research Ethics Committee in September 2012.

9. Anonymity

I spoke to the organizations when negotiating access with them, to determine if they wanted to remain anonymous or not. I also spoke to each participant to determine if they wanted to remain anonymous. I have used pseudonyms for the participants who wanted to remain anonymous.

10. Confidentiality

Confidentiality was ensured in the following ways. First, interviews were generally held in private rooms. Secondly, measures were taken to ensure that data collected was kept in a safe, private place. Thirdly, clients received write-ups of their interviews. They were able to decide if the way they have been represented was valid and fair. If they were not happy with any of their quotes chosen then I removed the quotes.

11. Data Analysis and Interpretation

The type of information that was collected through this study included literature as well as personal and social information from participants. Data gathered provided descriptive information on the study phenomenon. The qualitative data gathered included: transcriptions of audio recorded, in-depth interviews³⁹⁸ and field notes. Data from the transcriptions were collated into commonly occurring units of meaning. These units of meaning were collapsed to form codes. From these codes the main themes concerning barriers to access were delineated and discussed.

398 Mack et al op cit note 381.

CHAPTER FOUR: STUDY FINDINGS

SECTION 1: DESCRIPTION OF PARTICIPANTS' REFUGEE CLIENTS

1. Introduction

This Chapter describes the participants' female refugee clients and the six themes which emerged from this study. These themes reflect common barriers faced by female refugees in accessing mental health services in the Cape. They are 'Institutional Barriers', 'Language Barriers', 'Transport Barriers', 'Cultural and Religious Barriers', 'Work and/ or Childcare Responsibilities' and 'Individual Barriers'. While these themes are not all-encompassing, they were the most commonly identified by participants.

2. The Gatekeepers and Participants

Some of the participants and organizations wanted to remain anonymous. Pseudonyms have been provided for these participants.

Three participants from two NGOs were interviewed. One of the NGOs wanted to remain anonymous in order to protect refugee clients accessing their services. The participant working at this NGO was given the pseudonym 'Sarah'. The other NGO which was willing to be named was Scalabrini. I interviewed two individuals at Scalabrini, Rebecca and Marcel. A private counsellor, Morgan, who does pro bono work with refugees was also interviewed.

All the public institutions and the participants working there wanted to remain anonymous and thus have been given pseudonyms. The two participants working at the hospitals will be referred to as 'Lauren' and 'Bernice'. The participants from the clinics will be referred to as 'Mpho' and 'Josephine'.

3. Descriptions of Participants' Refugee Clients

3.1. Countries of Origin

The majority of refugee clients came from the DRC³⁹⁹. There were also many from Rwanda⁴⁰⁰, Burundi⁴⁰¹, Somalia⁴⁰² and Zimbabwe⁴⁰³. Other countries of origin were Uganda⁴⁰⁴, Tanzania⁴⁰⁵, Nigeria⁴⁰⁶ and Congo Brazzaville⁴⁰⁷. Not all participants saw clients from the same countries of origin. The difference in client demographics could be influenced by the location of the services and by factors such as 'word of mouth'⁴⁰⁸. Client demographics also fluctuate over time depending on what is happening in their communities and countries of origin⁴⁰⁹.

3.2. Why these Countries?

'We've definitely noted the effects of the violence in Goma and North Kivu (DRC), and the on-going human-rights abuses in Rwanda are causing a continuous flow of Rwandans... It's a big problem and those are seriously traumatised people.' (Rebecca)

There is a large Congolese community in the Cape which could account for the high number of Congolese clients seen⁴¹⁰. The on-going conflict in this region and the recent unrest in Goma have led to an increase in refugees from this region⁴¹¹. Many Congolese

399 Sarah, 21 November 2012, (transcribed interview; p. 3); also see Marcel, 6 December 2012, (transcribed interview); also see Lauren, 3 December 2012, (transcribed interview) at 7; also see Rebecca, 5 December 2012, (transcribed interview) at 4; also see Bernice, 3 December 2012, (transcribed interview) at 4; also see Morgan, 29 November 2012, (transcribed interview) at 2.

400 Josephine, 22 November 2012, (transcribed interview) at 5; also see Rebecca op cit note 399 at 4; also see Morgan op cit note 399 at 2.

401 Sarah op cit note 399 at 3.

402 Rebecca op cit note 399 at 4; also see Bernice op cite note 399 at 4; also see Josephine op cit note 400 at 5; also see Morgan op cit note 399 at 2.

403 Mpho, 28 November 2011, (transcribed interview) at 4; also see Marcel op cit note 399 at 1; also see Rebecca op cit note 399 at 4; also see Bernice op cite note 399 at 4.

404 Sarah op cit note 399 at 3; also see Josephine op cit note 400 at 5.

405 Mpho op cit note 403 at 4.

406 Ibid.

407 Morgan op cit note 399 at 2.

408 'Word of Mouth' - where individuals in a community are aware of a particular institution offering a service and thus more refugees from that country of origin access services at a particular institution.

409 Rebecca op cit note 399; also see Marcel op cit note 399 at 2; also see Bernice op cite note 399 at 4.

410 Rebecca op cit note 399 at 4; also see Baruti Amisi & Richard Ballard 'In the Absence of Citizenship: Congolese refugee struggle and organisation in South Africa' (2005) *A case study for the UKZN project entitled: Globalisation, Marginalisation & New Social Movements in Post-Apartheid South Africa*, available at <http://ccs.ukzn.ac.za/files/Amisi%20Ballard%20Refugees%20Research%20Report.pdf>.

411 Marcel op cit note 399 at 2; also see Bernice op cite note 399 at 4; also see Lauren op cit note 399 at 7; also see Rebecca op cit note 399 at 3.

female refugees have experienced war rape which also accounts for the high level of trauma amongst this group⁴¹².

The number of traumatised Rwandan refugees being seen could be owing to the increasing instability and human rights abuses in Rwanda⁴¹³. Also the level of torture and trauma experienced by Rwandans during the 1994 genocide has left many of these refugees extremely traumatised⁴¹⁴.

The Zimbabweans accessing services are both economic migrants and refugees⁴¹⁵. The percentage of them seen could be linked to the high numbers of Zimbabweans in SA.

3.3. Location of Refugees in the Cape

The refugee clients come from throughout the Cape Metropole⁴¹⁶. Areas include: Observatory, Retreat⁴¹⁷, Steenberg, Joe Slovo, Gugulethu⁴¹⁸, Phillipi⁴¹⁹, Langa⁴²⁰, Tafelsig, Mitchell's Plain⁴²¹, Woodstock⁴²², Kraaifontein⁴²³, Paarl, Mowbray, Grassy Park⁴²⁴, Maitland⁴²⁵, Wynberg, Muizenberg, Capricorn⁴²⁶, Parklands, Table View⁴²⁷ and the Northern Suburbs⁴²⁸. Most of the refugees seen came from poorer communities⁴²⁹.

Reasons given for refugees coming from these areas were that: these are the public health facilities' catchment areas⁴³⁰; refugee shelters (which refer clients) are in these areas⁴³¹; and for various reasons refugees tend to live in these areas (rent is reasonable; there is less xenophobia than in the townships and these are often areas where other

412 Morgan op cit note 399 at 2.

413 James Karuhanga 'Rwanda: Is FDLR Regrouping?' *The New Times* 14 January 2013, available at <http://allafrica.com/stories/201301140117.html?page=2>; also see Rebecca, 7 January 2013, personal communication (email).

414 Morgan op cit note 399 at 2; also see Lisa Lopez Levers 'Addressing Urgent Community Mental Health Needs in Rwanda: Culturally Sensitive Training Interventions' (2006) *Journal of Psychology in Africa*, available at http://www.researchgate.net/publication/233382716_Addresssing_Urgent_Community_Mental_Health_Needs_in_Rwanda_Culturally_Sensitive_Training_Interventions.

415 Marcel op cit note 399 at 1.

416 Sarah op cit note 399 at 3; also see Morgan op cit note 399 at 3.

417 Ibid.

418 Sarah op cit note 399 at 3.

419 Mpho op cit note 403 at 3.

420 Morgan op cit note 399 at 3.

421 Josephine op cit note 400 at 5&6; also see Marcel op cit note 399 at 2.

422 Josephine op cit note 400 at 5&6.

423 Morgan op cit note 399 at 3.

424 Ibid.

425 Marcel op cit note 399 at 2.

426 Ibid.

427 Rebecca op cit note 399 at 5&6.

428 Bernice op cite note 399 at 6.

429 Morgan op cit note 399 at 3.

430 Marcel op cit note 399 at 2; also see Mpho op cit note 403 at 3&4; also see Bernice op cit note 399 at 6.

431 Lauren op cit note 399 at 7; also see Mpho op cit note 403 at 3&4; also see Rebecca op cit note 399 at 4.

members of the refugee community live⁴³².) It was difficult to determine whether the relatively low number of refugees seen from townships was because fewer of them live in these communities, or if it was owing to additional barriers to access in townships.

3.4. A Comparison of Female to Male Refugees Accessing Services

The hospitals tended to see more refugees than the clinics. Lauren said that approximately 2% of the psychiatric clients at her hospital are refugees⁴³³. Bernice said that the difference between numbers of mentally ill female and male refugees accessing her hospital differs over time. However, generally they see more males. Currently the hospital is seeing two or three male refugees but no females⁴³⁴. She also said that generally in the Western Cape more males access acute psychiatric services⁴³⁵, possibly owing to the higher rates of substance abuse amongst males in this province⁴³⁶. Substance abuse has led to increased levels of males entering psychiatric facilities with Substance-induced Psychotic Disorder and other mental disorders triggered by substance abuse⁴³⁷. This phenomenon was reiterated by a participant working at a clinic⁴³⁸.

Each clinic participant had only ever treated one mentally ill female refugee, despite the fact that both had worked in their facilities for at least three years⁴³⁹. Josephine had never seen another refugee client. Mpho, however, was currently seeing three male refugees⁴⁴⁰.

Gender differences amongst refugees accessing mental health services in the non-governmental sector, differed between participants. Sarah sees two to three female refugees per month but overall she sees a lot more male refugees⁴⁴¹. Morgan generally sees three to four female refugees per month. More female than male refugees access her services with about a three to one ratio⁴⁴². The likely reason for this gender difference is because she has

432 Marcel op cit note 399 at 2; also see Morgan op cit note 399 at 4.

433 Lauren op cit note 399 at 6.

434 Bernice op cite note 399 at 6.

435 Dana JH Niehaus, Liezl Koen & Ushma Galal et al 'Crisis discharges and readmission risk in acute psychiatric male inpatients' (2008) 8 *BioMed Central Psychiatry* at 44, available at <http://www.biomedcentral.com/1471-244X/8/44>.

436 Karl Peltzer, Shandir Ramlagan, Bruce D. Johnson & Nancy Phaswana-Mafuya 'Illicit Drug Use and Treatment in South Africa' (2011) 45(13) *Substance Use Misuse* 2221- 2243, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3010753/>; also see SA Federation for Mental Health (SAFMH) '2012-2013: Youth and Mental Health Overview', available at <blogs.sun.ac.za/mhic/files/2011/09/2012-2013-overview.docx>.

437 Bernice op cit note 399 at 3; also see Mpho op cit note 403 at 3.

438 Mpho op cit note 403 at 1.

439 Ibid; also see Josephine op cit note 400 at 1.

440 Mpho op cit note 403 at 1.

441 Sarah op cit note 399 at 1.

442 Morgan op cit note 399 at 1.

worked for a long time in the sexual violence sector and more women tend to admit to experiencing sexual violence so they are more often referred to her⁴⁴³.

All Rebecca and Marcel's clients are refugees. Approximately 35% of Rebecca's clients are female and about 50% of Marcel's clients are female. Marcel sees about 200 female refugees per month. Rebecca sees around 30 new female clients per month (Sometimes this number increases to 60 depending on the month)⁴⁴⁴. However, not all of them have mental health problems.

Most participants said that the male to female ratio of clients fluctuated, often depending on external triggers⁴⁴⁵. The conflict in Goma⁴⁴⁶ has resulted in an increase in Congolese female refugees accessing services at Scalabrini⁴⁴⁷. Xenophobic attacks in specific communities will increase the number of those clients being seen⁴⁴⁸. Rebecca often sees more mentally ill female refugees during winter as during this time people become more desperate and there is more domestic violence⁴⁴⁹.

3.5. Age Range

The refugees seen were generally between the ages of 20 and 40⁴⁵⁰. There are a number of reasons for this age range. First, the refugee population tends to consist of more mobile individuals. Younger individuals will generally find it easier to flee and are more willing to seek new opportunities⁴⁵¹. Elderly people often find it harder and are more fearful to flee their country⁴⁵². Secondly, there may be higher levels of stigma regarding mental health services amongst elderly refugees⁴⁵³. Thirdly, female refugees in this age group often experience multiple stressors. Stressors include sexual assault, the burden of childcare and domestic abuse.

443 Ibid.

444 Marcel op cit note 399 at 1; also see Rebecca op cit note 399 at 1.

445 Morgan op cit note 399 at 1; also see Rebecca op cit note 399 at 3.

446 Pete Jones 'Reports of rape and looting by DRC soldiers' *AlJazeera* 27 November 2012, available at <http://www.aljazeera.com/indepth/features/2012/11/2012112710129408185.html>.

447 Rebecca op cit note 399 at 3.

448 Ibid at 2; also see Sarah op cit note 399.

449 Rebecca op cit note 399 at 3.

450 Sarah op cit note 399; also see Morgan op cit note 399 at 2; also see Marcel op cit note 399 at 1; also see Rebecca op cit note 399 at 3; also see Bernice op cit note 399 at 6; also see Josephine op cit note 400 at 5; also see Mpho op cit note 403 at 3.

451 Marcel op cit note 399.

452 Ibid; also see Rebecca op cit note 399 at 3&4.

453 Morgan op cit note 399 at 2.

3.6. Common Conditions

Josephine's female refugee client had Bipolar which she felt was linked to mental illness in this client's family. However, this client was also experiencing numerous social stressors which could have triggered the breakdown she experienced in SA⁴⁵⁴.

Mpho's female client had Bipolar while her male refugee clients had Schizophrenia and Substance-Induced Psychotic Disorder⁴⁵⁵. Mpho mentioned how one of her schizophrenic clients had been stable until the xenophobic attacks in 2008. The trauma he experienced during this time triggered a psychotic episode⁴⁵⁶.

Rebecca said substance abuse is a common trigger for mental illness amongst male refugees, while trauma and stress are common triggers amongst female refugees⁴⁵⁷. She believes there are extremely high levels of undiagnosed depression and PTSD amongst the female refugees she sees⁴⁵⁸. The impact of extreme social stressors faced by female refugees (particularly mothers) on mental health was reiterated by another participant⁴⁵⁹.

Bernice said that substance abuse was not a problem amongst the refugees she saw. However, she then related a story of a refugee client with PTSD who had become an alcoholic⁴⁶⁰. There was a high prevalence of schizophrenia amongst her refugee clients. Many of them have experienced some post-traumatic stress symptoms which could be a trigger for the development of their psychiatric disorders⁴⁶¹.

One participant mentioned that the majority of her refugee clients had a history of psychiatric illness. A few of them were brought to SA by their families so that they could access better psychiatric services⁴⁶². Therefore, she felt that their conditions were not necessarily trauma-induced or triggered by traumatic experiences. However, she later mentioned that few of her female refugee clients have opened up about whether they have experienced trauma. Thus, I would argue that she cannot be certain that traumatic events or the stressors linked to being a female refugee did not trigger some of her clients' mental breakdowns.

454 Josephine op cit note 400 at 6.

455 Mpho op cit note 403 at 3.

456 Ibid at 4.

457 Rebecca op cit note 399 at 20.

458 Ibid at 5.

459 Lauren op cit note 399 at 7.

460 Bernice op cit note 399 at 4.

461 Ibid at 4&5.

462 Lauren op cit note 399 at 11.

4. Exposure to Trauma

‘By definition a genuine refugee would very rarely not have directly experienced some trauma.’ (Rebecca)

The majority of the participants believed that exposure to trauma was high amongst the female refugee population⁴⁶³. Sarah said most clients had experienced pre-migration, migration, and post-migration trauma. Morgan said that all the refugee clients she sees have been exposed to multiple and extreme traumas. However, she said that this is partly due to the fact that she works with extreme trauma cases, so not all female refugees living in the Cape have necessarily experienced such trauma⁴⁶⁴.

4.1. Pre-Migration Trauma

If we’re speaking about past traumas, things that have occurred or which they’ve been exposed to in their own countries, it’s beatings; it’s having watched their families being slaughtered; its having returned home to where the village is completely destroyed, there’s nothing left and they need to be on the run. It’s having to leave children behind and then trying to bring them out of the danger zone; for many of the clients it’s political rape... (Sarah)

Most participants described a high prevalence of pre-migration trauma amongst their clients⁴⁶⁵. Traumatic experiences included: torture; rape; watching family members being killed⁴⁶⁶; and leaving family, friends, home and culture behind⁴⁶⁷. Marcel described an encounter with a female client and her four year old daughter who had both faced rape in their home country. When asked to draw a picture the little girl drew a picture of the trauma she had experienced. It was still vivid in the child’s mind. Other participants also mentioned the horrific war rape and torture experienced by their clients⁴⁶⁸. One of Lauren’s female clients when faced with the option of repatriation said:

‘I would rather die in South Africa than to go back to those circumstances’.

463 Marcel op cit note 399 at 3.

464 Morgan op cit note 399 at 4.

465 Marcel op cit note 399; also see Rebecca op cit note 399; also see Morgan op cit note 399; also see Sarah op cit note 399 at 3.

466 Bernice op cit note 399 at 4.

467 Marcel op cit note 399 at 2; also see Morgan op cit note 399 at 6&7.

468 Rebecca op cit note 399 at 5; also see Bernice op cit note 399 at 5; also see Morgan op cit note 399; also see Marcel op cit note 399.

Not only the trauma they faced but the day-to-day survival struggles made life incredibly difficult for these refugees in their home countries⁴⁶⁹. Many refugees are not only fleeing trauma, but seeking a destination of perceived opportunities⁴⁷⁰.

4.2. Trauma during Migration

But I think the trauma of the journey is completely underestimated, especially women who have to journey with children.... thousands and thousands of kilometres, you don't know where your next meal is coming from. You ask this driver for help, you are at his mercy. You are at his mercy... (Rebecca)

As described in the literature review the migratory process can also be traumatic. This was emphasised by some of the participants⁴⁷¹. It is particularly traumatising for women and for mothers journeying with their children. These women are vulnerable to general violence and to sexual exploitation by truck drivers and border guards⁴⁷². Other traumatic migratory experiences recounted were: losing family members (one participant mentioned how her client had lost her children during the migratory process and only found them a year later⁴⁷³) while other clients had family members who were never found⁴⁷⁴; fleeing on foot for long distances⁴⁷⁵; struggling to find food for themselves and their children; and fear of the unexpected⁴⁷⁶.

4.3. Trauma and Stressors once in South Africa

'....They are living in the fear here. Fear to be attacked by neighbours, fear of being reported, fear of not having enough to survive, you know. Those are the kinds of fear.'

(Marcel)

Traumatic experiences in SA were also common amongst clients. This post-migration trauma was similar in some ways and differed in other ways from pre-migration traumatic experiences. Trauma and stressors experienced in the Cape compounded previous harrowing experiences⁴⁷⁷. For some clients these experiences were worse than their pre-

469 Lauren op cit note 399 at 8&9.

470 Mpho op cit note 403.

471 Morgan op cit note 399 at 4.

472 Rebecca op cit note 399 at 5&6.

473 Ibid at 6&7.

474 Mpho op cit note 403 at 6.

475 Rebecca op cit note 399 at 6&7.

476 Ibid at 5, 6&7.

477 Morgan op cit note 399 at 5; also see Marcel op cit note 399 at 2; also see Rebecca op cit note 399 at 5.

migration traumas⁴⁷⁸. Post-migration traumas included: sexual assault⁴⁷⁹; generalised violence⁴⁸⁰; xenophobic attacks (such as homes and businesses being destroyed)⁴⁸¹; struggling to cope with a partner with PTSD; domestic abuse; staying in communities with other traumatised individuals⁴⁸²; financial difficulties⁴⁸³; raising children with limited financial and social support⁴⁸⁴; and the high crime rate⁴⁸⁵. Further stressors and traumas included being abandoned by husbands and partners and trying to find lost loved ones⁴⁸⁶. Violence in the Cape differs in certain ways from previous traumatic experiences such as genocide; rape by large group of soldiers and constant gunfire. Trauma in Cape Town is more unpredictable⁴⁸⁷. The nature of this trauma often differs depending on the community they are living in. Clients from areas such as Observatory, experience crime such as robbery and are not generally targeted because of their identity. However, clients coming from townships experience more xenophobic-related trauma⁴⁸⁸. Sexual violence and other violent crime are commonly experienced by female refugees. The constant fear from living in a violent society, exacerbated by PTSD symptoms of hyper-arousal, makes life in Cape Town incredibly anxiety-provoking.

Further post-migration stressors include having to learn the intricacies of a new society and having to rebuild their life⁴⁸⁹. They have to make new friends, build new social networks and learn new languages⁴⁹⁰. Finding shelter and food is another stressor particularly for single mothers⁴⁹¹. They are faced with the asylum application process which is particularly challenging in the Western Cape at the moment owing to the Department of Home Affairs' refusal to reopen the Maitland Refugee Reception Centre⁴⁹².

478 Marcel op cit note 399 at 3.

479 Sarah op cit note 399 at 4; also see Rebecca op cit note 399 at 5.

480 Rebecca op cit note 399 at 5.

481 Sarah op cit note 399 at 4; also see Mpho op cit note 403 at 4.

482 Sarah op cit note 399 at 4; also see Rebecca op cit note 399 at 4.

483 Sarah op cit note 399 at 4; also see Lauren op cit note 399 at 7.

484 Lauren op cit note 399 at 7; also see Rebecca op cit note 399 at 5.

485 Morgan op cit note 399 at 4.

486 Rebecca op cit note 399 at 7; also see Lauren op cit note 399 at 6&7.

487 Morgan op cit note 399 at 4.

488 Ibid; also see Sarah op cit note 399 at 3&4.

489 David R. Johnson 'Helping Refugee Trauma Survivors in the Primary Care Setting' (2005) *The Centre for Victims of Torture*, available at

http://www.cvt.org/sites/cvt.org/files/u11/Helping_Refugee_Trauma_Survivors_Primary_Care.pdf.

490 Marcel op cit note 399 at 3; also see Johnson op cit note 489.

491 Rebecca op cit note 399 at 7.

492 CoRMSA op cit note 179; also see Vigneswaran op cit note 179; also see IRIN op cit note 132; also see Amisi & Ballard op cit note 410; also see SABC 'Home Affairs ordered to reopen Maitland Refugee Reception Centre' *SABC Digital News* 25 July 2012, <http://www.sabc.co.za/news/a/67d525004c1b49e6a671af8b30ab6902/Home-Affairs-ordered-to-reopen-Maitland-refugee-reception-centre-20122507>.

Finally, the fear of not coping adds to this stress⁴⁹³. The daily post-migration stressors can be the final triggers for a mental breakdown⁴⁹⁴.

493 Marcel op cit note 399 at 2.

494 Ibid at 3.

SECTION 2: DESCRIPTIONS OF THEMES – BARRIERS TO ACCESS TO MENTAL HEALTH SERVICES

1. Theme 1: Institutional Barriers

‘Institutional Barriers’ reflect how female refugees’ right to access psychiatric services is being upheld or impinged on at the institutional level. It further addresses how policies relating to this right are being applied. Five institutional barriers have been identified.

1.1. Barriers in the Referral System

According to Section 6(1)(b) of the Mental Health Care Act, health establishments must refer mentally ill clients ‘...according to established referral and admission routes to a health establishment that provides the appropriate level of mental care, treatment and rehabilitation services.’ The referral system of mentally ill female refugees in the Cape is described by one of the participants:

‘...[It is] fragmented and hit and miss. In some instances I’ve had good responses. In others it’s taken me months and months and months of writing letters and phoning and asking and getting nowhere...’ (Morgan)

If a person becomes dangerously psychotic in the community, the police are required to take this individual to a health establishment to be psychiatrically assessed⁴⁹⁵. Clients must generally undergo a 72 hour psychiatric observation at a state secondary hospital to determine if they require inpatient admission to a tertiary psychiatric institution⁴⁹⁶. Owing to their high case load, psychiatric hospitals are unable to admit a person directly from the community except in cases where a client is well-known at the institution or was recently discharged and then relapsed. The four tertiary mental institutions in the Western Cape are Stikland, Lentegeur, Valkenberg and Alexandra Hospital⁴⁹⁷.

If a client is dangerously psychotic then a service provider should phone the police to come and take the client for psychiatric assessment⁴⁹⁸. According to the Mental Health

495 s40 (1)(a) of the Mental Health Care Act 17 of 2002.

496 Crick Lund, Piet Oosthuizen & Alan J. Flisher et al ‘Pathways to Inpatient Mental Health Care Among People With Schizophrenia Spectrum Disorders in South Africa’ (2010) 61(3) *Psychiatric Services*, available at <http://ps.psychiatryonline.org/article.aspx?articleid=101220>.

497 Lauren op cit note 399 at 1&2; also see Western Cape Government op cit note 257.

498 s40 (1)(a) of the Mental Health Care Act 17 of 2002.

Care Act, if the client is non-violently psychotic a relative or health provider can take them for psychiatric assessment⁴⁹⁹. Unfortunately, refugees do not always have family members who can take them⁵⁰⁰. Furthermore, organizations, without health providers, are not able to refer a non-violent psychotic client for psychiatric assessment if the client refuses⁵⁰¹.

There was a general consensus amongst public health participants that the public mental health referral system works well⁵⁰². One participant was unaware of any referral barriers facing refugees⁵⁰³. However, the response was different in the NGO sector. Sarah said her organization received few referrals from public health facilities. The referrals they did receive were mainly from NGOs working specifically with refugees⁵⁰⁴. She believes this is due to a lack of awareness amongst those in the public health sector of the existence of some of these refugee NGOs they can refer to⁵⁰⁵. Owing to the very heavy work-load of mental health workers in the public and NGO sector it can be difficult to find time to collaborate with other NGOs concerning refugee clients' multiple needs⁵⁰⁶.

Another difficulty is trying to refer a client for counselling, when it is clear they are not coping, but they do not open up (This is a particular problem with refugees). It is difficult to refer clients to an organization for counselling, if one cannot provide a specific reason for the referral⁵⁰⁷.

1.2. Documentation Barriers and Lack of Awareness of Refugees' Rights

Amongst participants there was a difference of opinion concerning whether or not refugees needed specific documentation to access mental health services at primary level clinics⁵⁰⁸. All said that lack of documentation was not a barrier at their institution. However, some participants mentioned that when referring to other mental health services it had sometimes been an issue. Lack of documentation and sorting out the social needs of refugees was incredibly time-consuming and placed an extra responsibility on overworked health providers. While this is not an excuse for discriminatory treatment, it does explain why mental health providers are sometimes more reluctant to serve refugees.

499 s26 & s27 (1) (a) (i) & (ii) of the Mental Health Care Act 17 of 2002.

500 Ibid; also see Marcel op cit note 399 at 4.

501 Ibid; also see Rebecca op cit note 399 at 12&13.

502 Josephine op cit note 400 at 10&11; also see Mpho op cit note 403 at 14.

503 Lauren op cit note 399 at 13.

504 Sarah op cit note 399 at 8.

505 Ibid at 9.

506 Ibid at 7.

507 Rebecca op cit note 399 at 7.

508 Lauren op cit note 399; also see Mpho op cit note 403; also see Josephine op cit note 400.

1.3. Xenophobic and Discriminatory Attitudes

‘...I’ve met some very lovely health care providers who, who try their best with very little resources, but there are others who are appalling in their attitude and frankly xenophobic.’ (Morgan)

All the participants that I interviewed displayed a positive, concerned attitude towards refugees and all affirmed the right of refugees to access psychiatric services on the same standing as citizens. However, this may not be the generally-held attitude amongst mental health providers in the Cape.

One of the public health participants said that xenophobic attitudes amongst staff could be a barrier⁵⁰⁹. However, she had never heard of this occurring at her institution⁵¹⁰. The others were not certain whether it was an issue but all said that refugees accessing their services were treated the same as South Africans, regardless of documentation⁵¹¹. Two institutions mentioned the right of refugees to complain to the Mental Health Review Board if they were unhappy with their treatment. Mpho said that xenophobic attitudes of other clients may hinder female refugees from seeking treatment, as refugees are blamed for everything in the communities:

‘Even if there was no medication in the pharmacy definitely they would blame the foreigners “It is them that are making our place so full, and now we cannot even have enough medication!”’ (Mpho)

Most of the NGO sector participants recounted xenophobic incidents experienced by their clients from clerks and staff at public health facilities⁵¹². Xenophobia was more common amongst clerks and frontline workers than medical professionals⁵¹³. However, there were some accounts of xenophobic attitudes amongst health professionals⁵¹⁴. Morgan described two xenophobic encounters experienced by her refugee clients. One incident was where she took an acutely-ill female refugee to a hospital for an emergency referral. She had phoned prior to leaving and was told she could bring the client in. They waited for six hours before being seen. After explaining the client’s story, staff told them that they were at

509 Bernice op cit note 399 at 9.

510 Ibid at 9&15.

511 Lauren op cit note 399 at 10; also see Bernice op cit note 399 at 5; also see Mpho op cit note 403.

512 Sarah op cit note 399 at 7.

513 Rebecca op cit note 399 at 10.

514 One participant mentioned that there is sometimes tension between Congolese doctors and Rwandese clients (Morgan).

the wrong hospital. If she had not contained the client, the client would not have coped. Another acutely-ill refugee she took to a hospital was placed in a general rather than a psychiatric ward. The general ward was so full the client was made to sleep in a chair in the ward for the whole weekend⁵¹⁵. The client was resistant to accessing public psychiatric care after that.

Sometimes what appear to be xenophobic attitudes could instead be lack of awareness of refugees' rights and confusion of institutional policies as a result of high staff - turnover⁵¹⁶. Furthermore, what appears to be xenophobia could rather be poor care as a result of staff being over-worked⁵¹⁷. Discriminatory treatment is often haphazard, being dependant on the knowledge and attitude amongst the clerks on duty on a particular day⁵¹⁸.

1.4. Under-Resourced Mental Health Services

Lack of funding, resources and overall capacity was a barrier described by all participants. There are limited places to refer clients to for counselling⁵¹⁹. There is a lack of resources for holistic case management which is often required to effectively deal with refugees and is a practice common in more well-resourced countries⁵²⁰. Owing to lack of consistent funding for NGOs services are too few and too short-term⁵²¹. It is difficult for NGOs to access funding for counselling, particularly for refugees⁵²². Additional funding is needed for refugee counselling services as refugees generally have multiple needs. Funding for interpreters is difficult to access⁵²³. The loss of funding for Rape Crisis Centre in the past year is further reducing counselling services for citizens and refugees who have been victims of sexual assault⁵²⁴.

Conditions like PTSD require intensive long term treatment. Unfortunately, the extent and nature of counselling services available in the Cape is often insufficient to properly treat it⁵²⁵. Few counsellors in both the NGO and public sector have the training or

515 Morgan op cit note 399 at 6.

516 Rebecca op cit note 399 at 10.

517 Crush & Tawodzera op cit note 325.

518 Rebecca op cit note 399 at 10.

519 Ibid at 7.

520 Morgan op cit note 399 at 5; also see CAMH op cit note 58.

521 Morgan op cit note 399 at 5.

522 Ibid at 9.

523 Ibid at 10.

524 Rebecca op cit note 399 at 21; also see Katharine Child 'Cape Town rape crisis trust faces risk of closure' *Mail & Guardian* 1 November 2011, available at

<http://mg.co.za/article/2011-11-01-cape-town-rape-crisis-trust-faces-closure>

525 Rebecca op cit note 399 at 3&6.

experience required to deal with the extreme levels and complex nature of trauma faced by many female refugees⁵²⁶.

There are insufficient staff and services available to meet the high demand for mental health care in the Cape⁵²⁷. Owing to high levels of substance-induced psychosis⁵²⁸ and the HIV/ AIDS pandemic hospitals in the Cape face the challenge of acute bed pressure⁵²⁹. Not all clinics in the Cape offer psychiatric services. Psychiatric nurses often work at a number of clinics and cover large areas⁵³⁰. Staff are carrying a high case-load and have minimal time to see each client⁵³¹.

It is particularly time-consuming to work with refugees with mental health disorders. This places an extra burden on already overburdened staff and services⁵³².

1.5. Staff Compassion Fatigue

I think what happens with a lot of mental health workers... when they're faced with such a big mix of primary trauma and...extreme human sadness...It...becomes quite overwhelming and I've seen some mental health workers just stepping out because they can't, there's not enough help to, to actually do anything. (Morgan)

There is a lot of compassion fatigue⁵³³ amongst those working in the mental health sector in the Cape⁵³⁴. Two participants mentioned the frustration and stress of working in psychiatry in an overburdened public mental health sector. They felt that because of their high case load they are unable to provide quality in-depth care⁵³⁵. Working with refugees can be emotionally-draining. It was described as 'wearying and exhausting' by one participant⁵³⁶. This work can result in vicarious traumatisation and compassion fatigue,

526 Ibid at 13; also see Morgan op cit note 399 at 5; also see CAMH op cit note 58.

527 Rebecca op cit note 399 at 22; also see Mpho op cit note 403 at 11; also see WHO op cit note 235; also see IRIN op cit note 5.

528 Bernice op cit note 399 at 11&12.

529 Ibid at 10; also see Rebecca op cit note 399 at 22; also see Mpho op cit note 403 at 11; also see J Corrigan, C Ward & K Stinson 'Decreasing the Burden of Mental Illness' (2007) 4 *Western Cape Burden of Disease Reduction Project: Final Report 2007*, available at http://www.westerncape.gov.za/Text/2007/6/cd_volume_4_mental_health_disorders.pdf; also see Vearey & Nunez op cit note 21; also see Lund et al op cit note 496.

530 Mpho op cit note 403 at 11; also see Josephine op cit note 400.

531 Sarah op cit note 399 at 6.

532 Bernice op cit note 399 at 12; also see Morgan op cit note 399 at 5&10; also see Rebecca op cit note 399 at 11.

533 Definition of Compassion Fatigue: the inability to react sympathetically to a crisis, disaster, etc, because of overexposure to previous crises, disasters, etc (Collins English Dictionary (2013), available at <http://www.collinsdictionary.com/dictionary/english/compassion-fatigue>)

534 Morgan op cit note 399 at 6&7.

535 Mpho op cit note 403 at 11; also see Rebecca op cit note 399 at 22.

536 Morgan op cit note 399 at 5&6.

resulting in service providers sometimes being reticent to counsel refugees⁵³⁷. The vicarious traumatising of mental health providers and refugee workers is often overlooked in SA and there is insufficient ‘Caring for the Carer’⁵³⁸.

2. Theme Two: Language Barriers

‘The main barrier...the first barrier is language problems. Because when you have to counsel someone or if you have to access medical care, you must be able to explain yourself...Most of the people they just decide not to go, not to use that place.’ (Marcel)

You know, and sometimes it could also be, could be the language barrier. I mean, a lot of the refugees don’t speak maybe English. Or don’t speak proper English. And you know they can’t really, you know, communicate what is wrong with them. So, so only when they really become psychotic and the family takes them to the hospital, and then we figure out “Ok, you know, there is something. Maybe there is a mental illness, now.” (Josephine)

The most commonly mentioned barrier was language⁵³⁹. Some even described it as the biggest barrier⁵⁴⁰. While English is the Lingua Franca in the majority of mental health services in the Cape, many refugees there are not from English speaking nations⁵⁴¹. Language can be a barrier to awareness of services and to communication during consultations⁵⁴². Some facilities may disregard refugees because of the communication barrier⁵⁴³. As a result, psychiatric illness may go undiagnosed, until the refugee becomes acutely ill⁵⁴⁴. If a refugee is thought-disordered or is experiencing bizarre delusions, it may be hard to determine because of communication difficulties⁵⁴⁵. Unfortunately, many institutions face difficulties in accessing and funding trained mental health interpreters⁵⁴⁶.

Even if refugees are able to communicate in basic English, in-depth discussions are difficult. Some participants mentioned how there are a few staff at their institutions who could speak a refugee language, and they would sometimes be called on during

537 Ibid at 6&7.

538 Rebecca op cit note 399 at 22.

539 Josephine op cit note 400; also see Morgan op cit note 399; also see Marcel op cit note 399; Rebecca op cit note 399; also see Lauren op cit note 399 at 4; also see Bernice op cit note 399 at 9; also see Mpho op cit note 403 at 23.

540 Josephine op cit note 400 at 8; also see Morgan op cit note 399 at 6&10; also see Marcel op cit note 399 at 3.

541 Josephine op cit note 400 at 5; also see Gerard Drennan & Leslie Swartz ‘A concept over-burdened Institutional roles for psychiatric interpreters in post-apartheid South Africa’ (1999) 4(2) *Interpreting* p. 169–198, available at http://asli.org.uk/files/downloads/65_interpreting%20in%20psychiatry.pdf.

542 Josephine op cit note 400 at 5; also see Lauren op cit note 399 at 4.

543 Lauren op cit note 399 at 20.

544 Josephine op cit note 400 at 8.

545 Lauren op cit note 399 at 20.

546 Morgan op cit note 399 at 5&10; also see Rebecca op cit note 399 at 22.

consultations. However, this could be problematic for two reasons. First, these staff have other job demands and cannot be called on at any time. Secondly, translators can impinge on client confidentiality and can be a barrier to clients opening up⁵⁴⁷.

Rebecca mentioned how male refugees often have a better grasp of English than females⁵⁴⁸. This is particularly common in Somali communities, where most women stay at home. This makes it much harder for them to learn English and may make them more apprehensive to seek psychiatric care.

3. Theme Three: Transport Barriers

‘It’s harder to get out of bed never mind open the door and...or sit down or take a train or walk somewhere, you know. People collapse. They can’t stand up actually.’

(Morgan)

Transport was another commonly mentioned barrier to access except in most acute cases. The cost of transport can be prohibitive and using public transport can be dangerous for refugees. When clients are acutely ill they are generally transported to the hospital by ambulance or the police.

3.1. Cost

While indigent refugees are not required to pay for public health care and NGO services, the cost of travelling to the clinic can be a barrier. Transport costs are particularly difficult for the unemployed and those living far from mental health services⁵⁴⁹. For many destitute clients who are struggling to buy food, the cost of transport is an insurmountable barrier⁵⁵⁰. When the choice is between buying food for the family versus accessing mental health services many female refugees will prioritise the former. Some, but not all institutions cover transport costs.

Secondly, using public transport can be time consuming. Refugees may feel that they cannot justify taking time off work to access mental health services⁵⁵¹.

547 Smith op cit note 342.

548 Rebecca op cit note 399 at 17.

549 Josephine op cit note 400 at 9, 13&20; also see Morgan op cit note 399 at 11; also see Bernice op cit note 399 at 8; Rebecca op cit note 399 at 13.

550 Rebecca op cit note 399 at 13.

551 Mpho op cit note 403.

Thirdly, many refugee mothers have nowhere to leave their children during counselling. Taking their children with them increases transport costs⁵⁵². Clients, therefore, sometimes resort to dangerous childcare practices, such as locking their children up at home while they go for counselling⁵⁵³. Rebecca mentioned an incident where a mother had done this and her child had had a serious accident while she was out⁵⁵⁴.

3.2. Danger

Using public transport can be dangerous for refugees⁵⁵⁵. Some have experienced violence, specifically xenophobic attacks, on public transport. At one stage Metrorail had a special phone line to report xenophobic attacks on the trains⁵⁵⁶.

‘Apart from harsh words and threats on trains and in buses and taxis... there was a Rwandese man who was beaten to death in a train, just down here.’ (Morgan)

Morgan mentioned that owing to traumatic experiences on public transport, she sometimes has to fetch clients from their homes for counselling. While this can blur the boundaries of the client –counsellor relationship, it is pointless having a client take a train before she has been treated for her traumatic train experience⁵⁵⁷. Even those who have not experienced attacks are wary of using public transport⁵⁵⁸. Walking to counselling can also be dangerous as illustrated in this quote:

‘If you don’t have money, then you must walk and walking as a refugee...I mean... a South African is not able to walk freely, so how much more to them, knowing that they are being targeted? So that can also be a barrier for them not to come.’ (Mpho)

Some female refugees, especially those from central Africa and Somalia need to be accompanied by men when travelling⁵⁵⁹. This is both a cultural practice and a means of protection⁵⁶⁰. However, this can also be a barrier as females may not want their male

552 Morgan op cit note 399 at 11; also see Rebecca op cit note 399 at 14.

553 Rebecca op cit note 399 at 14.

554 Ibid.

555 Anonymous ‘Mugabe Beaten to Death in Xenophobic Attack’ *I Luv South Africa but hate my Government* 31 July 2010, available at http://iluvsa.blogspot.com/2010_07_01_archive.html;

556 Morgan op cit note 399 at 10&11.

557 Ibid.

558 Rebecca op cit note 399 at 13&14.

559 Marcel op cit note 399 at 6; also see Morgan op cit note 399 at 14.

560 Marcel op cit note 399 at 6.

chaperone to know why they are accessing counselling⁵⁶¹. The language barrier may also make female refugees fearful of travelling or walking by themselves⁵⁶². If they get lost they may not know how to ask for directions or who they can trust to ask⁵⁶³.

4. Theme Four: Cultural and Religious Barriers

I had a case in the last xenophobic attacks in July for example. I had a [Somalian] man who came here. The attackers, the South Africans came in, they attacked the shop, they raped the wife in front of the man and beat the man and his assistant up. The two men were taken to the hospital and the woman was dumped in Bellville. I couldn't get them to take her to the hospital. They didn't see the rape as legitimating a trip to the hospital for the woman. It just wasn't an issue.... Men are prioritised. Women are primarily there to cook and have children... their mental health... is not even an issue. It's not on the table. (Rebecca)

4.1. Patriarchal Norms

Rebecca said she has seen Somali men but never seen Somali women presenting with mental disorders. Sarah also said that she has never counselled a Somali woman though she has counselled a number of Somali males⁵⁶⁴. On broaching this subject with Somali male clients the response has been 'No, no, no, I'll come to you, my wife is fine⁵⁶⁵.' It was suggested that owing to patriarchal norms, Somali women with psychiatric problems are often kept in their communities because their mental health needs are not prioritised.

Bernice said that though Somali culture was patriarchal, she had not experienced this as a barrier to access⁵⁶⁶. Furthermore, the only refugee client that Josephine had seen was a Somali female. She spoke very good English, was well educated and had a supportive husband. Not all Somali female refugees are necessarily subject to the same patriarchal cultural norms. Nevertheless, such norms may be pervasive and a significant barrier⁵⁶⁷.

While patriarchal norms are particularly strong in the Somali community, they are also prevalent in other refugee communities⁵⁶⁸. In the DRC gender inequality is rife and the

561 Ibid at 7.

562 Rebecca op cit note 399 at 8; also see Morgan op cit note 399 at 10&11.

563 Morgan op cit note 399 at 10&11.

564 Sarah op cit note 399 at 2.

565 Ibid at 3.

566 Bernice op cit note 399.

567 Josephine op cit note 400 at 5.

568 Spirasi 'Congo – Democratic Republic of Congo' *Cultural Profile*, available at <http://cultural.profiles.spirasi.ie/countries/congo%20drc.shtml>.

majority of women require their husbands' permission before doing things such as accessing services⁵⁶⁹.

4.2. Perceptions of Mental Illness

Cultural differences were viewed by some participants as a barrier. Others were unclear about the cultural and religious perceptions of mental illness amongst their refugee clients.

In the DRC sexual violence in war as well as domestic violence are highly prevalent⁵⁷⁰. Yet, trauma and harsh circumstances are rarely perceived as being risk factors for mental illness there⁵⁷¹. The terms used to describe, and the perceptions of what constitutes mental illness differ depending on the culture⁵⁷². Often individuals were only perceived as psychiatrically disturbed when they became psychotic. Depression and anxiety were generally not seen as mental illness unless extremely severe. Some refugees' explanations of mental illness included: that the person had been bewitched⁵⁷³; cursed⁵⁷⁴ or demon possessed⁵⁷⁵.

In the DRC and Somalia there is shame and stigma associated with psychiatric illnesses and accessing mental health services⁵⁷⁶. They therefore do not openly discuss mental illness⁵⁷⁷. Many Somali refugees follow Sunni Islamic 'fatalistic' beliefs. Some do not access treatment because they believe that their suffering is God's will⁵⁷⁸. Many despise those who complain about ill-health and view emotionality as a sign of weakness⁵⁷⁹. Women from these cultures often present with somatization or conversion

569 This is more pervasive in the rural areas (Spirasi op cit note 568; also see Refugee Council 'A guide to Congolese cultural and social norms' (December 2004), available at http://www.refugeecouncil.org.uk/Resources/Refugee%20Council/downloads/practice/advisers_info/congol_cult_dec04.pdf.)

570 Refugee Council op cit note 569.

571 Ibid.

572 Bernice op cit note 399 at 13; also see Lauren op cit note 399 at 18.

573 Mpho op cit note 403 at 17; also see Lauren op cit note 399 at 18.

574 Refugee Council op cit note 569.

575 Lauren op cit note 399 at 18; also see Rebecca op cit note 399 at 15; also see David McGraw Schuchman & Colleen McDonald 'Somali Mental Health' (2004) *Bildhaan – An International Journal of Somali Studies*, available at <http://ethnomed.org/clinical/mental-health/somali-mental-health>; also see Spirasi op cit note 568; also see Bernard Guerin, Abdirizak Abdi & Pauline Guerin 'Experiences with the Medical and Health Systems for Somali Refugees living in Hamilton' (2003) 32(1) *New Zealand Journal of Psychology*, available at <http://nzrefugeeresearch.wikispaces.com/file/view/Experiences+with+medical+and+health+systems+for+Somali+refugees+living+in+Hamilton.pdf>.

576 Spirasi op cit note 568; also see McGraw & McDonald op cit note 575.

577 Refugee Council op cit note 569; also see Jagoda Pasic, Brian Poeschla & Lorin Boynton et al 'Cultural Issues in Emergency Psychiatry: Focus on Muslim Patients' (2010) 17(7) *Primary Psychiatry* p. 37-43, available at <http://www.cnsspectrums.com/asp/articleDetail.aspx?articleid=2704>.

578 McGraw & McDonald op cit note 575.

579 Ibid.

disorders as physical ailments are more acceptable than psychiatric conditions⁵⁸⁰. This could be another reason why fewer Somali female refugees access psychiatric care.

Lauren mentioned that the mentally-ill are treated harshly in some refugees' cultures⁵⁸¹. Common practices include: sending the person away to a traditional healer for treatment; casting out demons; healing the individual and throwing their medication away⁵⁸²; and fastening the individual to a tree⁵⁸³. Rebecca said she thinks that mentally ill males are more commonly 'sent away' to traditional healers than females⁵⁸⁴. Female refugees are more often kept at home or sent back to their home country⁵⁸⁵.

4.3. Accessing Treatment

In countries like the DRC, people rarely go for counselling and only access psychiatric care where an individual is dangerously psychotic⁵⁸⁶. If you refer a Congolese person for counselling they may think you are suggesting they are psychotic and 'crazy'⁵⁸⁷. If a client is depressed or anxious they tend to rely on their family members for support. However, in SA many do not have family to call on.

In refugees' home countries many people access spiritual and traditional healers for treatment⁵⁸⁸ and only access 'western' mental health care as a last resort⁵⁸⁹. This finding was reiterated in a study conducted on mentally ill Indochinese immigrants to Australia⁵⁹⁰. Some refugees are non-compliant to 'western' psychiatric medication, because they view traditional medicines as superior and 'western' medication as unable to treat the root cause of the illness⁵⁹¹. However, this is not always the case. Some participants' refugee clients were compliant and went out of their way to access psychiatric treatment.

580 Jagoda et al op cit note 577; also see Johnson op cit note 489.

581 Lauren op cit note 399 at 19.

582 Rebecca op cit note 399 at 15.

583 Lauren op cit note 399 at 18.

584 Rebecca op cit note 399 at 19.

585 Rebecca, 10 January 2012, personal communication (email)

586 Marcel op cit note 399 at 4.

587 Ibid.

588 Marcel op cit note 399 at 4; also see Mpho op cit note 403 at 17; also see Bernice op cit note 399 at 13; also see Spirasi op cit note 568; also see McGraw & McDonald op cit note 575; also see Guerin et al op cit note 575.

589 Mpho op cit note 403 at 18; also see Johnson op cit note 489.

590 Anthony P. Lam & David J Kavanagh 'Help seeking by immigrant indochinese psychiatric patients in Sydney, Australia' (1996) 47(9) *Psychiatric Services* p. 993-995, available at <http://psycnet.apa.org/psycinfo/1996-93997-017>.

591 Lauren op cit note 399 at 18; also see McGraw & McDonald op cit note 575; also see Guerin et al op cit note 575.

One participant said that Congolese refugees may prefer to use traditional treatment, although it is often ineffective⁵⁹². However, Bernice said that unlike some of her Xhosa and Zulu clients, none of her refugee clients had ever requested to visit a traditional healer⁵⁹³. She believed that fear of xenophobia can be a barrier to their visiting these healers⁵⁹⁴. Traditional healers are also often very expensive, so accessing them is difficult for impoverished refugees⁵⁹⁵.

The practice of going to traditional healers is lower within religious communities⁵⁹⁶. Religious individuals who are suspicious of psychiatric treatment may prefer accessing the local pastor for prayer, exorcism or healing⁵⁹⁷. While religion can be a barrier to access and compliance, some participants described how pastors, church members and imams had referred clients to them or ensured clients were accessing their treatment⁵⁹⁸.

Refugees may find it easier to receive mental health advice from someone from their culture⁵⁹⁹ or a service provider who is culturally sensitive⁶⁰⁰.

4.4. Gender as a Barrier

The gender of service providers can also be a barrier. If a woman is referred for counselling to a man or finds out, upon arrival, that the service provider is male she may leave or refrain from opening up during the consultation⁶⁰¹.

4.5. Conclusion

Most refugees have limited experience of being referred for counselling and so they do not know what it entails⁶⁰². Counselling is a foreign concept to many of them⁶⁰³. Cultural or religious barriers to access differ, depending on the specific culture and level of education of the refugee. Studies have shown that refugees and migrants with higher levels of education are more likely to access psychiatric services⁶⁰⁴.

592 Marcel op cit note 399 at 4.

593 Bernice op cit note 399 at 13.

594 Ibid.

595 Morgan op cit note 399 at 13

596 Spirasi op cit note 568.

597 Ibid.

598 Rebecca op cit note 399 at 15; also see Lauren op cit note 399 at 14&15.

599 Josephine op cit note 400 at 19.

600 Ibid at 21; also see Jagoda et al op cit note 577.

601 Marcel op cit note 399 at 5; also see Jagoda et al op cit note 577.

602 Marcel op cit note 399 at 9; also see Rebecca op cit note 399 at 19.

603 Ibid; also see Lauren op cit note 399 at 18.

604 Peifer et al op cit note 285.

5. Theme Five: Work and Childcare Responsibilities

Caring and providing for one's family is often prioritised over counselling, with some viewing counselling as a luxury⁶⁰⁵. Many refugee women spend the majority of their time ensuring their family survives⁶⁰⁶. This includes home-making and childcare duties, as well as working outside the home. Most do not feel that they can take time off to seek mental health care.

5.1. Work

'I think for a lot of our clients it's a matter of "I need bread and milk on my table. I don't need counselling now."' (Sarah)

Mpho described how the female refugees in her community are very hard-working, with many working seven days a week⁶⁰⁷. Josephine reiterated this. Her client, while recognising the importance of treatment, had missed an appointment and collecting her medication because of work⁶⁰⁸. For refugees who lack official refugee status, the lack of documentation prevents them from accessing disability grants⁶⁰⁹. For many the only way to survive is to work⁶¹⁰. One participant mentioned that those accessing her services want to gain more than 'just' counselling from it⁶¹¹.

Many refugees minimise their symptoms because they are afraid that by acknowledging their condition and taking time to receive treatment, they may lose their jobs. Unfortunately, in the end, many become so ill that they have to be admitted to hospital⁶¹².

605 Morgan op cit note 399 at 16; also see Sarah op cit note 399 at 13; also see Rebecca op cit note 399 at 8&19.

606 Rebecca op cit note 399 at 8&19.

607 Ibid at 19&20.

608 Josephine op cit note 400 at 18.

609 CTRC 'Social Services' (2008) *CTRC Refugee Information Guide*, available at <http://www.ctrco.co.za/upload/Social%20Services.pdf>

610 Mpho op cit note 403 at 19&20.

611 Sarah op cit note 399 at 10.

612 Bernice op cit note 399 at 15.

5.2. Childcare Responsibilities

‘It’s very difficult for them to come for counselling holding a baby like this, and sometimes the baby’s crying. So they just decide to stay at home.’ (Marcel)

Childcare is a major barrier as often a disproportionate childcare burden is placed on females⁶¹³. Many of the female refugees are coming from patriarchal societies where women’s needs are subjugated to those of men⁶¹⁴. They are at home to cook, clean and care for the children⁶¹⁵. Other refugee mothers are abandoned by their husbands’ when they arrive in SA⁶¹⁶. There are many single refugee women managing large numbers of children without the financial support of their partner. While being under incredible stress, many are focused on providing for their children and do not consider accessing psychiatric services⁶¹⁷.

Rebecca described the problematic consequences of refugee mothers’ untreated mental disorders on the well-being of their children. While these mothers may be reticent to access services because of family responsibilities, the children often suffer the effects of their mother’s untreated condition. This may also exacerbate their own traumatic experiences⁶¹⁸. If single refugee mothers collapse under the strain, there may be no-one to care for the children⁶¹⁹.

6. Theme Six: Individual Barriers

6.1. Fear of Shame and Rejection

In many refugee cultures it is common for a woman who has been raped to be thrown out of the house by her husband or partner ‘as soiled goods’⁶²⁰. Marcel said that the majority of female rape victims he had worked with in DRC were too ashamed to tell their husbands

613 Rebecca op cit note 399 at 14; also see Morgan op cit note 399 at 11.

614 Spirasi op cit note 568; also see CTRC op cit note 609.

615 Rebecca op cit note 399 at 8&19.

616 Ibid at 20&21.

617 Ibid.

618 Ibid.

619 Ibid at 19.

620 Morgan op cit note 399 at 10&11; also see Rebecca op cit note 399 at 14; also see Marcel op cit note 399 at 7; also see Giroin et al op cit note 284.

that they had been raped⁶²¹. Many also face rejection from their families and communities⁶²² as the stigma associated with rape is pervasive in many of these communities⁶²³. Some rape victims have fled their country because their entire community have stigmatised or rejected them⁶²⁴. Consequently, many female refugees in the Cape who have been raped will try to conceal this fact. They may avoid counselling, as this would require an explanation⁶²⁵. Some refugees who suffer extensive physical damage from rape, do not even access medical services owing to the stigma⁶²⁶.

One of Sarah's clients was reluctant to access counselling, because of how she thought her husband viewed the rape. However, in this particular case the husband wanted her to seek counselling because her reaction to the rape was 'pulling him down'⁶²⁷. This illustrates how ingrained cultural norms on shame can be a barrier for women.

Marcel mentioned that a high percentage of married refugee women coming from central Africa are economically dependent on their husbands. Their rejection may lead to destitution⁶²⁸. This dependence makes these women wary of upsetting their husbands by going for counselling.

6.2. Fear of Facing Past Traumas

'..For refugees it's rare that they open up to us, and they tell us of the traumas that they have experienced..... It's unlike the South Africans because most South African patients when asked, when they are stabilised, would open up.' (Lauren)

Refugee clients may take a long time to share their traumatic experiences. At the primary health care level, where clients are generally seen for a short session once a month, it is impossible to fully deal with clients' traumatic experiences. Female refugees often do not disclose these experiences because they see no benefit in doing so⁶²⁹.

Furthermore, many refugees are wary of trusting someone enough to share deeply with them⁶³⁰. They fear that confidentiality will not be maintained. Yet, those who are

621 Marcel op cit note 399 at 7.

622 Morgan op cit note 399 at 15.

623 Ibid.

624 Ibid; also see Marcel op cit note 399 at 8.

625 Morgan op cit note 399 at 14; also see Rebecca op cit note 399 at 14.

626 Morgan op cit note 399 at 14&15.

627 Sarah op cit note 399 at 12.

628 Marcel op cit note 399 at 8.

629 Lauren op cit note 399 at 9.

630 Johnson op cit note 489.

able to trust a service provider enough to share their experiences find relief in doing so. They can finally be honest with someone and know that they will not be betrayed⁶³¹.

It can be challenging for clients to open up to counsellors about their experiences. Some are in denial or are trying to block out traumatic memories⁶³². While treatment can lessen the traumatic experiences from haunting the client, facing up to these experiences can be terrifying⁶³³. Refugees may fear that acknowledging that the trauma has affected them means that they are weak, ‘crazy’ or have been broken by the trauma⁶³⁴. Many pressurise themselves to cope because others in their communities have experienced similar traumas and appear ‘unbroken’ by it⁶³⁵.

6.3. Lack of Insight into their Condition and Need for Treatment

Female refugees often lack awareness that they have a mental illness and would benefit from treatment⁶³⁶. It can be difficult to motivate them to access psychiatric services⁶³⁷. This is a common problem amongst mentally ill clients⁶³⁸. Psychotic clients often do not see that they are ill because they believe their delusions⁶³⁹. With neurotic disorders, many female refugees do not view the symptoms they are experiencing as indicative of a mental illness⁶⁴⁰. They also do not realise the lasting impact of trauma on well-being⁶⁴¹.

The data collected suggested that barriers were greater when the mental illness was less severe⁶⁴². It appeared that refugees were reticent to seek help until they had a break down. It is easier to refer those who become dangerously psychotic for psychiatric care because they can be involuntarily admitted⁶⁴³.

631 Morgan op cit note 399 at 16.

632 Rebecca op cit note 399 at 8; also see Sarah op cit note 399 at 15; also see Morgan op cit note 399 at 12

633 Morgan op cit note 399 at 12.

634 Ibid; also see Rebecca op cit note 399 at 15; also see Johnson op cit note 489.

635 Rebecca op cit note 399 at 15.

636 Lauren op cit note 399 at 15.

637 Rebecca op cit note 399 at 12&13.

638 Ibid at 13.

639 Rebecca op cit note 399 at 19; also see Lauren op cit note 399 at 18.

640 Rebecca op cit note 399 at 15.

641 Morgan op cit note 399 at 12; also see Johnson op cit note 489.

642 Mpho op cit note 403 at 20.

643 Ibid; also see Bernice op cit note 399 at 4.

6.4. Lack of Awareness of Available Services or how to Navigate Services

6.4.1. Lack of Awareness of Available Services

Lack of awareness of mental health services is a barrier for many refugees. ‘Word of mouth’ is often the way they hear about counselling. However, some clients owing to fear or stigma may be reluctant to tell others that they are accessing these services⁶⁴⁴. Globally, mental illness has a stigma but this is often exacerbated for refugees who already face the stigma of being ‘foreigners’⁶⁴⁵. This could inhibit them from inquiring about services. Congolese and Burundian refugees often isolate themselves and so are less likely to be aware of available treatment⁶⁴⁶.

6.4.2. Difficulty in Navigating Available Services

One participant mentioned the challenge of navigating public health institutions. She described how she had taken an acutely psychotic client to a local hospital. She had had difficulty finding admissions and was sent from one doctor to the next. Her concern was that if she found it challenging, how much harder it must be for female refugees⁶⁴⁷. Not only are services often difficult to access but the actual building and waiting room are often very intimidating. This must be particularly daunting for female refugees, many of whom have anxiety symptoms and struggle to communicate in English. The experience of being in a crowd of strangers can be terrifying for them⁶⁴⁸. Their anxiety and vulnerability may drain them of the emotional or physical energy to access services⁶⁴⁹. Another participant described how her clients, who have been sexually assaulted, often ask her to explain in referral letters what happened to them so that they do not have to explain to the nurse themselves⁶⁵⁰.

644 Morgan op cit note 399 at 13.

645 Lauren op cit note 399 at 14; also see Bernice op cit note 399 at 11.

646 Sarah op cit note 399 at 5.

647 Rebecca op cit note 399 at 12.

648 Ibid.

649 Ibid at 9.

650 Morgan op cit note 399 at 14&15.

CHAPTER 5: DISCUSSION

1. Introduction

In this chapter, I discuss the findings in relation to the thesis question and the objectives of this study. The thesis question aimed to determine the main barriers to accessing mental health services in the Cape Metropole, faced by female refugees who have been exposed to trauma. The objectives were: identifying the right of female refugees in the Cape Metropole to access public mental health services and to identify government policies relating to the promotion and protection of this right. Further objectives included determining the extent to which this right is being upheld and promoted and the specific areas where this right is being impinged on. The final objective aimed to identify and explore the nature of the specific barriers to access to public mental health facilities faced by female refugees in the Cape. Relevant literature has been drawn upon in considering the findings in relation to the thesis question and the objectives.

2.1. Theme One: Institutional Barriers

2.1.1. Barriers in the Referral System

There was a difference in position between the Public Health Sector (PHS) participants and those in the NGO sector as to the effectiveness of the referral system. While the PHS participants thought the referral system was good and worked well this was not the general consensus amongst those in the NGO sector. Non-governmental participants felt that the referral process was inconsistent. Sometimes the process was smooth and referrals were welcomed and sometimes participants spent extensive time trying to refer clients with little success. Lack of referrals and inconsistency in the referral system could be due to heavy workloads⁶⁵¹. Some participants felt that the PHS lacked awareness of NGOs they could refer refugees too. Referrals received by non-governmental workers were primarily from other NGOs working with refugees. The PHS participants, however, mentioned receiving referrals from NGOs and other PHS facilities. Thus referrals from the public sector to NGOs may be fewer and less consistent than vice-versa.

Certain technicalities in the referral system hindered referrals. Non-governmental participants mentioned the difficulty associated with trying to refer non-violent psychotic

651 Crush & Tawodzera op cit note 325.

refugees for 72 hour assessment. These clients can only be admitted to hospital if a) they consent⁶⁵²; b) a family member/ next of kin takes them⁶⁵³; or c) referred by a health provider. However a) few non-violent psychotic refugees presenting at NGOs consent to going to hospital (owing to lack of insight); b) many do not have family members who can take them to the hospital and; c) if there are no health providers at the NGO they cannot refer them for direct assessment⁶⁵⁴.

While the Mental Health Care Act emphasizes the importance of referring clients to appropriate level of care and the referral structure appears viable, inconsistent practices and technicalities hamper refugee referrals⁶⁵⁵. Increased networking between public and NGO sector mental health providers could improve this situation⁶⁵⁶. It could be argued that even if a psychotic individual does not display dangerous behaviour, they are a potential danger to themselves or others⁶⁵⁷. First, their future actions are unpredictable and secondly, if psychosis is left untreated it will lead to further mental deterioration⁶⁵⁸. In the absence of consent, a family member and a health provider, special consideration should be given for a professional refugee worker to make emergency referrals for non-violent psychotic refugees.

2.1.2. Documentation Barriers and Lack of Awareness of Refugees' Rights

All PHS participants mentioned that according to the Mental Health Care Act it was the right of refugees to access services on an equal standing as citizens⁶⁵⁹. However, there was a lack of consensus regarding whether or not documentation was required to access services at all levels. This lack of clarity on documentation and refugees' rights has resulted in inconsistency in provision of mental health services to refugees in the Cape. Permits are often requested before refugees can access services⁶⁶⁰. Some health providers

652 s9 (1)(a) of the Mental Health Care Act 17 of 2002; also see Western Cape Government op cit note 257.

653 Western Cape Government op cit note 257.

654 s25- 40 of the Mental Health Care Act 17 of 2002.

655 Mental Health Care Act 17 of 2002.

656 WHO 'Community Systems Strengthening Framework', available at http://www.who.int/tb/dots/comm_hss.pdf; also see CAMH op cit note 58.

657 Brown University 'Schizophrenia', available at http://www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/Schizophrenia.pdf.

658 Mental Health Evaluation & Community Consultation Unit 'Early Identification of Psychosis' *Primer for Ministry of Health, Province of British Columbia*, available at http://www.health.gov.bc.ca/library/publications/year/misc/Psychosis_Identification.pdf; also see SCMH op cit note 115.

659 The Mental Health Care Act of 2002 requires that it be interpreted consistently with constitutional provision. The Constitution allows for refugees and asylum seekers to access health services. (s27 of the SA Constitution of 1996 and s27 (a) of the South African Refugee Act of 1998); also see CTRC op cit note 311.)

660 CTRC op cit note 311.

also demand that an identity document, proof of residence, most recent payslip or income assessment (IRP5), referral letter and home address be provided⁶⁶¹.

What does the Mental Health Care Act actually say? Is any form of identifying documentation needed? Do documentation requirements differ between primary, secondary and tertiary level?

The Mental Health Care Act does not specifically require documentation in order to access psychiatric services⁶⁶². Furthermore, according to the National Department of Health's Directive in 2007, refugees, asylum seekers and undocumented migrants cannot be barred from accessing any health services (whether primary, secondary or tertiary), because of lack of appropriate documentation⁶⁶³. Rather, according to Section 32 (3) of the SA Refugee Act an asylum seeker who is mentally ill must be assisted in their application for refugee status⁶⁶⁴. Therefore, rather than turn away an undocumented mentally ill asylum seeker, mental health providers must, in addition to providing them with psychiatric care, assist them in accessing correct documentation⁶⁶⁵.

However, sorting out documentation places an added burden on extremely busy mental health providers. This can make them more reticent to serve refugees. While this is not an excuse for discriminatory practices it provides an understanding for why it occurs⁶⁶⁶.

Even though, legally, lack of documentation is not a barrier⁶⁶⁷, there is a lack of general understanding and consistent application of the right of refugees with inadequate documentation to access services⁶⁶⁸. This inconsistency slows down the referral process and makes accessing mental health care more difficult for this population⁶⁶⁹. This barrier can be overcome through training of staff at health institutions on refugees' right to access health services.

2.1.3. Xenophobia and Discriminatory Attitudes

While the PHS participants were generally not aware of xenophobic attitudes amongst staff towards refugees, the majority of participants working in the NGO sector recounted

661 Crush & Tawodzera op cit note 325; also see Western Cape Government op cit note 257.

662 Mental Health Care Act of 2002.

663 Breen & Gwyther op cit note 36; also see Crush & Tawodzera op cit note 325.

664 'Any mentally disabled person who appears to qualify for refugee status in terms of section 3 must be assisted in applying for asylum in terms of this Act.' (s32(3) of the South African Refugee Act of 1998)

665 Ibid.

666 Crush & Tawodzera op cit note 325.

667 Odhiambo op cit note 23.

668 Breen & Gwyther op cit note 36; also see Magardie op cit note 319; also see SAHRC op cit note 278.

669 Ibid.

xenophobic experiences faced by their clients in the PHS. It is difficult to determine why this difference in perception exists. It is possible that PHS staff were being loyal to their and other Public Health institutions and were therefore not recounting xenophobic incidents or staff were just unaware of xenophobic attitudes. Some staff appeared confused about what constituted xenophobic treatment, with some perceiving it as only referring to the xenophobic attacks in 2008⁶⁷⁰.

Xenophobic incidents were reported as more common amongst frontline workers such as clerks. This finding is consistent with studies on xenophobic attitudes amongst health providers in SA⁶⁷¹. It could be that Public Mental health providers are in less contact with frontline workers than referring NGOs and are less aware of these xenophobic attitudes. These attitudes could be more prevalent amongst frontline workers, as they often come from poorer communities where xenophobia is more common and are often less aware of refugees' rights⁶⁷². High staff turnover at many institutions may result in confusion regarding institutional policies and clients rights⁶⁷³.

One participant mentioned that fellow clients' xenophobic attitudes could hinder refugees accessing services⁶⁷⁴. This finding is supported by the 2006 survey conducted by The Southern African Migration Programme which indicated that only 27% of South Africans felt that refugees were entitled to access health care⁶⁷⁵. This study also indicated that a high proportion of South Africans perceived refugees as bringing diseases to SA and overwhelming the health services⁶⁷⁶.

While xenophobic attitudes are not experienced by all refugees accessing the health sector⁶⁷⁷, the fear of being badly treated could be a major deterrent⁶⁷⁸. Denial of access to services or receiving poor quality care is a violation of the right to health⁶⁷⁹. Refugees need to be informed of their right to complain to the Mental Health Review Board if they have been denied access or been ill-treated⁶⁸⁰. Furthermore, there must be education of and/or

670 Vromans et al op cit note 208; also see Crush & Tawodzera op cit note 325.

671 Breen & Gwyther op cit note 36; also see Odhiambo op cit note 23.

672 Breen & Gwyther op cit note 36.

673 Angeli Rawat 'Gaps and Shortages in South Africa's Health Workforce' *Africa Initiative* 14 June 2012, available at <http://www.africaportal.org/articles/2012/06/19/gaps-and-shortages-south-africa%E2%80%99s-health-workforce>.

674 Mpho op cit note 403.

675 Crush & Tawodzera op cit note 325.

676 Ibid.

677 Crush & Tawodzera op cit note 325.

678 Ilonda op cit note 325.

682 Crush & Tawodzera op cit note 325.

680 Art 3 of the South African Nursing Council's Code of Conduct; also see in Angus Dawson, Inez De Beaufort & Jayapalazaria 'The Genealogy of Informed Consent: South African Medical Association's Statement of Doctor's and Patient's Rights and Responsibilities' (November 2008) 31 *The Newsletter of the*

disciplinary action for service providers who display xenophobic and discriminatory behaviour.

2.1.4. Under-Resourced Mental Health Services

The lack of funding, resources and overall capacity in the public mental health and NGO sector in the Cape⁶⁸¹ is a problem for both refugees and citizens.

In the preamble to the Mental Health Care Act it states that mental health services should be ‘provided as part of primary...health services⁶⁸²’. Yet this is not the case with a number of clinics in the Cape Metropole⁶⁸³ which are particularly under-resourced⁶⁸⁴. Some clinics do not have mental health sisters. The mental health sisters I contacted were either servicing a number of clinics or covering extensive areas. Furthermore, there are insufficient mental health outreach clinics in the communities. Outreach clinics are essential in psychiatry where mentally-ill individuals often do not access treatment (and particularly pertinent to refugees who often lack insight into mental illness and/ or how to access treatment).

Refugees often have extensive, complex needs and require intensive, long term therapy which is generally unavailable⁶⁸⁵. Many refugees in the Cape are exposed to continuous trauma which compounds their previous traumas and hinders recovery⁶⁸⁶.

Counselling services for refugees are not prioritised for funding in SA⁶⁸⁷. Rape Crisis Centre and Saartjie Baartman (a centre for abused women and children⁶⁸⁸) are among a number of NGOs in the Cape which face an insecure future owing to decreased funding⁶⁸⁹. These NGOs have been filling a needed gap in the service sector for female victims of

International Association of Bioethics, available at <http://bioethics-international.org/news/iabnews-nov2008.pdf>; also see Crush & Tawodzera op cit note 325.

681 Davis op cit note 316; also see WHO op cit note 235; also see Lund et al op cit note 496.

682 Preamble to the Mental Health Care Act 17 of 2002.

683 F Gamielien ‘Mental Health Resource Directory 2004’ *Department of Health*

Provincial Administration of the Western Cape, available at

http://www.westerncape.gov.za/Text/2006/7/mh_resource_directory_optimised_fgamielien.pdf; also see WHO op cit note 235.

684 Lund et al op cit note 496.

685 U.S. Government Printing Office ‘Abandoned upon arrival: Implications for refugees and local communities burdened by A U.S. Resettlement system that is not working’ (21 July 2010) *A Report to the Members of the Committee on Foreign Relations, United State Senate One Hundred Eleventh Congress, Second Session*, available at <http://www.gpo.gov/fdsys/pkg/CPRT-111SPRT57483/html/CPRT-111SPRT57483.htm>; also see CAMH op cit note 58.

686 Morgan op cit note 399.

687 Ibid; also see Odhiambo op cit note 23; also see IRIN op cit note 5.

688 Ilse Ahrends ‘Saartjie Baartman Centre for Women and Children: Organization Description’ *Say No: Unite to End Violence Against Women*, available at <http://saynotoviolence.org/user/355>.

689 Davis op cit note 316.

trauma⁶⁹⁰. They provide services which should be provided by the government⁶⁹¹. The government has not only failed to protect refugee women in SA,⁶⁹² from sexual assault, but they have failed to provide and/or support⁶⁹³ available services to rehabilitate and compensate these victims⁶⁹⁴. This view is held by many private funders including international donors who are hesitant to provide funding for services which they see as the state's responsibility⁶⁹⁵. While the government claims that lack of resources is the reason for underfunding, many argue that government funding is often mismanaged and poorly prioritised⁶⁹⁶. How does one ensure the right of refugees to access needed psychiatric services when government claims a lack of resources?

While clearly, lack of resources is a barrier in our country this cannot be an excuse to do nothing about prevention of trauma and under-resourced psychiatric services. Article 12 (1) of the ICESCR requires SA as a ratifying state to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and *mental* health' (emphasis added). Violence against female refugees constitutes a violation of their right to health and indicates a failure of the state to 'protect' this right⁶⁹⁷. SA cannot be held accountable for atrocities committed in refugees' home countries, but we have a responsibility to protect refugees crossing the border and those in SA. We are failing to protect refugees from violence (both generalised and xenophobic). Thus we are failing to address a primary risk factor for the development or exacerbation of psychiatric conditions amongst refugees. Prevention is a key strategy of the PHC model, yet it is underutilized with regard to trauma in the Cape⁶⁹⁸. The state's failure to prevent trauma undermines the effectiveness of existing psychiatric treatment for traumatised refugees. No matter how accessible we make

690 Ibid.

691 Ibid.

692 Ursula A O'Hare 'Realizing Human Rights for Women' (1999) 21(2) *Human Rights Quarterly* 400.

693 State funding: 'cuts in state funding could be challenged at an international level as an indication of states' failure to take 'all appropriate measures' to eliminate violence against women, or, alternatively of its failure to guarantee equal protection of the laws.' (O'Hare (1999) 21(2) op cit note 692 at 400)

694 O'Hare op cit note 692 at 396; also see Hilary Charlesworth 'What are "Women's International Human Rights"?' in Rebecca J. Cook (ed) *Human Rights of Women: National and International Perspectives* (1994) 58-84.

695 O'Hare op cit note 692; also see Davis op cit note 316.

696 Davis op cit note 316; also see WHO 'Bridging the Gap in South Africa' (November 2010) 88(11)

Bulletin of the World Health Organization 797-876, available at

<http://www.who.int/bulletin/volumes/88/11/10-021110/en/index.html>; also see Mental Health and Poverty Project op cit note 238.

697 Office of the United Nations High Commissioner for Human Rights (OHCHR) 'The Right to Health: Fact Sheet 31' (June 2008) at 17, available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>; also see General Recommendations No. 19 (1992) of the Committee on the Elimination of Discrimination against Women (CEDAW) of 1979.

698 SA is in the process of implementing the PHC Model (Rita Magawa 'Primary health care implementation: A brief review' (16 August 2012) *Public Health Discussion Papers for Consultancy African Intelligence*, available at http://www.consultancyafrica.com/index.php?option=com_content&view=article&id=1096:primary-health-care-implementation-a-brief-review-&catid=61:hiv-aids-discussion-papers&Itemid=268.)

mental health services, without addressing violence, we will be unable to effectively treat refugees with trauma-related mental disorders. The Committee for the Elimination of All Forms of Discrimination against Women, not only requires states to ‘prevent, investigate and punish’ violence against women (including acts committed by private actors) but it requires state compensation, including rehabilitation for victims. SA has ratified the Convention on Elimination of All Forms of Discrimination Against Women of 1979 and is therefore bound by this requirement⁶⁹⁹.

According to Article 2 & 3 of the ICESCR states need to take immediate steps to progressively realise socio-economic rights, including the right to mental health care⁷⁰⁰, in a non-discriminatory way⁷⁰¹. Article 2 requires ratifying states to realise these rights according ‘to the maximum of its available resources’⁷⁰². This is reiterated by s27 (2) of the Constitution of SA⁷⁰³. Article 2 of ICESCR also calls upon states to request international assistance in order to realize these rights. However, there are minimum core obligations with regards to socio –economic rights which states have to immediately provide⁷⁰⁴. States are bound to fulfil these core obligations under International Human Rights Law (IHRL)⁷⁰⁵. These minimum core obligations require provision of primary health care, including mental health care⁷⁰⁶, that is available (in sufficient quantity⁷⁰⁷), accessible, acceptable and of good quality⁷⁰⁸. It appears that, for whatever reason, the SA government has failed to meet these core obligations.

Therefore, the government needs to start implementing specific progressive (not regressive!) measures to ensure that this right is being protected and fulfilled. This is not

699 OHCHR op cit note 697 at 17; also see General Recommendations No. 19 (1992) of CEDAW; also see General Comment No 9 of General Recommendations No. 19 (1992) of CEDAW; also see Special Recommendation 24 (k) of General Recommendations No. 19 (1992) of CEDAW; also see United Nations Treaty Collection ‘Ratification Status: South Africa’ *Convention on the Elimination of All Forms of Discrimination against Women of 1979*, available at http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en.

700 Art 12(1) of the ICESCR of 1966.

701 OHCHR op cit note 697.

702 Art 2(1) of the ICESCR of 1966.

703 s27 (2) of the Constitution of South Africa of 1996.

704 OHCHR op cit note 697.

705 United Nations Development Programme (UNDP) ‘Human Rights and The Millennium Development Goals: Making the Link’ (1 January 2007) *UNDP Primer*, available at http://www.undp.org/content/undp/en/home/librarypage/environment-energy/water_governance/human-rights-and-the-millennium-development-goals-making-the-link/.

706 Patients’ Rights Charter of 1999; also see CTRC op cit note 311.

707 OHCHR op cit note 697.

708 Ibid.

just a state obligation, but it is in their best interests owing to the economic burden that untreated psychiatric conditions place on our society⁷⁰⁹.

2.1.5. Staff Compassion Fatigue

Owing to the high burden of care and high prevalence of trauma there is a lot of compassion fatigue amongst staff workers in the Cape⁷¹⁰. Staff compassion fatigue and insufficient staff care in the Cape⁷¹¹ increases staff-turnover⁷¹², reduces the number of mental health workers and the quality of care they provide⁷¹³. Furthermore, secondary traumatisation and compassion fatigue can make providers⁷¹⁴ reticent to serve refugees.

While it is not acceptable to deny refugees access to services because they place an extra burden on services, it is also the role of the national and provincial health departments to provide mental health workers with sufficient support⁷¹⁵.

2.2. Theme Two: Language Barriers

Language was the most commonly mentioned barrier. This is one of the biggest barriers to health care faced by refugees globally⁷¹⁶.

The main languages spoken in mental health settings in the Cape are English, Afrikaans and isiXhosa⁷¹⁷. However, many refugees in the Cape are not proficient in these languages⁷¹⁸. Their main languages are French⁷¹⁹, Somali, siShona, Kinyarwanda⁷²⁰,

709 Odhiambo op cit note 23; also see Sarah Skeen & Crick Lund 'Achieving the Millennium Development Goals: Addressing Mental Health' *Mental Health Poverty Project*, available at <http://www.health.uct.ac.za/usr/health/research/groupings/mhapp/resources/SAHRC2.pdf>.

710 Vatiswa Veronica Makie *Stress and coping strategies amongst registered nurses working in a South African Tertiary Hospital* (unpublished MCur thesis, University of the Western Cape, 2006).

711 Crush & Tawodzera op cit note 325.

712 Crush op cit note 23.

713 Crush & Tawodzera op cit note 325.

714 Corrigal et al op cit note 695.

715 Ibid.

716 Morris et al op cit note 340.

717 Michellene Williams & Simon Bekker 'Language policy and speech practice in Cape Town: An exploratory public health sector study' (2008) 26(1) *Southern African Linguistics and Applied Language Studies* 171–183, available at <http://www.ajol.info/index.php/salas/article/view/6664>.

718 Scalabrini Centre of Cape Town 'Intern to SASA English School Manager' (2013) *GoAbroad.com*, available at <http://www.goabroad.com/providers/scalabrini-centre-of-cape-town/programs/intern-to-sasa-english-school-manager-116354>.

719 MapsofWorld.com 'Rwanda Language' (2009), available at

<http://www.mapsofworld.com/rwanda/rwanda-language.html>; also see Paul M. Lewis 'Languages of Burundi' in *Ethnologue: Languages of the World* 16 ed (2009), available at http://www.ethnologue.com/show_country.asp?name=bi.

720 Ibid.

Burundi – Rundi and Swahili⁷²¹. One participant mentioned how male refugees she sees often have a better grasp of South African languages than females. This has been reiterated in other South African and international studies⁷²².

Language poses a barrier in awareness of and ability to access services, and in treatment⁷²³. Communication difficulties may cause female refugees to feel that it is too great an effort to access services⁷²⁴. The communication barrier can also result in mental health providers misdiagnosing or not detecting psychiatric symptoms⁷²⁵.

While translators may remediate this barrier, securing and using them can be a challenge⁷²⁶. It is difficult to access properly trained translators and there is often limited if any funding available for them in the Cape. It would be challenging and expensive to provide translators for all refugee languages at all health facilities. Lay translators can also affect privacy and confidentiality⁷²⁷. Furthermore, it can be difficult to establish rapport with a client when there is an interpreter; this is particularly an issue for refugees who struggle to trust new acquaintances⁷²⁸.

Do refugees have a right to access services in their own language? What is the government's responsibility in this regard?

First, information accessibility forms part of the right to health care and thus national and provincial government and health providers must take active measures to overcome information barriers⁷²⁹. Strategies could include placing welcome signs outside clinics and hospitals in commonly spoken refugee languages and translating the Patient's Rights Charter of 1999 into the most prevalent of these languages⁷³⁰. Secondly, it is vital that health providers and clients are able to understand each other during consultations in order for the service to be effective and efficient⁷³¹. For clients who cannot speak English there should ideally be translators available. Even if not every establishment has a translator in the most common refugee languages, a network of translators should be accessible to

721 Ibid.

722 Guerin et al op cit note 575; also see Cindy Warner & Gillian Finchilescu 'Living with prejudice - xenophobia and Race' (2003) 55 *Southern African Migration Programme Briefing*, available at <http://www.queensu.ca/samp/migrationresources/xenophobia/research/warner.pdf>.

723 Crush & Tawodzera op cit note 325.

724 Peifer et al op cit note 285.

725 Jagoda et al op cit note 577.

726 Drennan & Swartz op cit note 542.

727 Smith op cit note 342.

728 Willis & Gonzalez (1998) in Jeon et al op cit note 80.

729 Crush & Tawodzera op cit note 325.

730 CoRMSA op cit note 179; also see CTCRC op cit note 311.

731 Crush & Tawodzera op cit note 325.

public health services⁷³². This would reduce the cost of providing translators in all common languages at every service site, but would still accommodate this barrier.

Ideally the public health and NGO sector should collaborate to train translators and counsellors from the refugee communities⁷³³ as such individuals would have a good grasp of these communities' culture and language⁷³⁴.

Thirdly, refugees must be provided with a means of reporting when they perceive health providers to be deliberately refraining from speaking a more commonly understood language such as English⁷³⁵. Finally, ideally the government should increase provision of English classes for refugees to facilitate their improved utilisation of health and other services and their integration into local communities⁷³⁶. While the SA Government cannot be held accountable for lack of provision of translators in every refugee language at every public health facility, they need to show that they are taking specific steps to overcome the language barrier which impinges on refugees' right to health⁷³⁷.

2.3. Theme Three: Transport Barriers

2.3.1. Cost

The cost of transport and the cost of taking time off work were seen as barriers. While some health services cover transport costs not all do. Furthermore, they are unable to cover costs for clients' children as well. Many refugee mothers must face the difficult decision of either leaving their children unattended at home or using their limited funds to pay to take their children with them⁷³⁸.

2.3.2. Danger

Female refugees are often fearful to travel by themselves, first, because of generalised crime and xenophobia experienced on public transport and secondly, because of language

732 CoRMSA op cit note 179.

733 Law et al op cit note 202.

734 Ibid.

735 Crush & Tawodzera op cit note 325; also see Melekias Zulu *Gaining an understanding of Umnyama from the Zionist Churches: A Case Study of Zimbabwean migrants in Johannesburg, South Africa* (unpublished MA thesis, Witwatersrand University, 2011), available at http://www.aucegypt.edu/gapp/cmrs/documents/philip%20culbertson_thesis.pdf; also see Ilondo op cit note 325.

736 Government of Canada 'The refugee system in Canada' (2012) *Citizenship and Immigration Canada*, available at <http://www.cic.gc.ca/english/refugees/canada.asp>; also see Morris et al op cit note 340.

737 OHCHR op cit note 697.

738 Warner & Finchilescu op cit note 722.

barriers and mistrust. Travelling with a male companion increases travel costs and might lead to unwelcome enquiries into their health problems. The danger experienced by female refugees on public transport in the Cape displays a failure of the government to protect them⁷³⁹.

Failure to protect is a violation of right to life, dignity, liberty and security of the person, bodily integrity, freedom of movement⁷⁴⁰, equal protection, as well as a violation of the cornerstone of refugee law, that of surrogate protection by asylum states⁷⁴¹. The state can be held accountable for this violence as it is widespread and they have failed to adequately prevent, investigate and punish perpetrators⁷⁴². One way to address this barrier would be to increase monitoring by police on trains to prevent xenophobic attacks.

2.4. Theme Four: Cultural and Religious Barriers

One of the main barriers appears to be religious and cultural. Refugees in SA are coming from a wide variety of countries with different religious and cultural practices. Most of those who were seen came from the DRC, Rwanda, Burundi, Somali and Zimbabwe⁷⁴³. This appears to be representative of the demographics of refugees entering SA as it is consistent with UNHCR figures on the main refugee nationalities in this country⁷⁴⁴.

While there appears to be a great need for mental health services amongst female refugees in the Cape, cultural and religious factors inhibit their service utilisation. These factors include: different perceptions of mental illness and treatment⁷⁴⁵; lack of awareness of neurotic diagnoses; stigma⁷⁴⁶; shame; religious fatalism; and strong patriarchal norms⁷⁴⁷.

739 Art 26 of the ICCPR of 1966 '[a]ll persons... are entitled without any discrimination to the equal protection of the law'; also see O' Hare op cit note 692 at 399.

740 Citizenship Rights in Africa Initiative (CRAI) 'Tolerating intolerance: Xenophobic Violence in South Africa' (July 2009) *CRAI Report*, available at <http://www.citizenshiprightsinafrica.org/Publications/2009/CRAISAReport.July2009.pdf>.

741 Charlesworth op cit note 694; also see James C. Hathaway & Michelle Foster 'Internal protection/relocation/flight alternative as an aspect of refugee status determination', available at <http://www.unhcr.org/419db69d4.pdf>; also see O' Hare op cit note 692; also see General Recommendation No. 19 (1992) of CEDAW.

742 O' Hare op cit note 692; also see Crush op cit note 23; also see CRAI op cit note 740; also see General Recommendation No. 19 (1992) of CEDAW; also see General Comment No. 9 of General Recommendations No. 19 (1992) of CEDAW.

743 Sarah op cit note 399 at 3; also see Marcel op cit note 399 at 1&2; also see Lauren op cit note 399 at 7; also see Rebecca op cit note 399 at 4; also see Bernice op cit note 399 at 4; also see also see Morgan op cit note 399 at 2; also see Josephine op cit note 400 at 5.

744 UNHCR op cit note 10.

745 McGraw & McDonald op cit note 575.

746 Lisa Lopez Levers, Desire Kamanzi & Donatilla Mukamana 'Addressing Urgent Community Mental Health Needs in Rwanda: Culturally Sensitive Training Interventions' (2006) 2 *Journal of Psychology in Africa* 261-272; also see Johnson op cit note 489.

747 Spirasi op cit note 568; also see Refugee Council op cit note 569.

In certain communities cultural norms appeared to be a barrier specifically for women accessing treatment. Female subjugation, lack of knowledge about western treatment, and language difficulties hindered access⁷⁴⁸. This appeared to be the case particularly with patriarchal norms in the Somali community. It was suggested that this was one of the reasons why so few Somali women in the Cape accessed mental health services⁷⁴⁹. However, it is hard to fully ascertain the extent to which patriarchal norms constitute a barrier, without interviewing the Somali refugee women themselves.

While cultural and religious barriers clearly exist, is it the role of the government to address them? Does this not impinge on cultural and religious rights? Should the government not respect refugee culture and leave refugee communities to decide if the women in their culture should access mental health care?

While s30⁷⁵⁰ and s31(1)(a)⁷⁵¹ and (2)⁷⁵² of the SA Constitution uphold and respect cultural and religious rights, they do not allow for these rights to be maintained at the expense of other Constitutional rights⁷⁵³. Some of the cultural and religious practices of the refugee communities impinge on s27 (the right to access health care including mental health care)⁷⁵⁴. Where patriarchal norms hinder females accessing mental health care, these norms undermine the right to equality⁷⁵⁵ enshrined in the Constitution⁷⁵⁶.

But does the SA government have a responsibility to actively address these barriers so that refugee women's rights to health are realised?

Part of a state's role in ensuring the right to health is to 'respect', 'protect' and 'fulfil' this right⁷⁵⁷. Female refugees with psychiatric illnesses are a particularly vulnerable group

748 Ibid.

749 Nimo Bokore 'Female survivors of African Wars: Dealing with the past and present' (2009) 1(1) *Journal of Sociological Research*.

750 s30 of the SA Constitution of 1996 states: 'Everyone has the right... to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights.'

751 s31(1)(a) 'Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community a) to enjoy their culture, practise their religion...'

752 s31(2) 'The rights in subsection (1) may not be exercised in a manner inconsistent with any provision of the Bill of Rights'.

753 s30 of the SA Constitution of 1996 states:

Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights.

It falls under right to mental health, the right to protect, the right to life and dignity and non-discrimination and equality.

754 s27 of the SA Constitution of 1966.

755 s9 (1) & (2) of the SA Constitution of 1966 states:

1. Everyone is equal before the law and has the right to equal protection and benefit of the law.
2. includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of Equality equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.

756 s9 of the SA Constitution of 1966.

757 UNDP op cit note 705 at 9.

and the government has a responsibility to target them in the protection and fulfilment of this right⁷⁵⁸. This can be done in four ways. First, under the obligation to ‘fulfil’ this right, the state needs to ensure that this right is promoted within the refugee communities⁷⁵⁹. This can be done through education and awareness-raising of mental illness, the impact it has and effective ways to treat it⁷⁶⁰. Secondly, there is a need to collaborate with traditional healers and religious leaders in the refugee communities to promote culturally relevant, holistic, psychiatric care⁷⁶¹. However, it is important that this collaboration does not undermine essential treatment⁷⁶². Thirdly, there is a need for more culturally sensitive mental health services for refugees⁷⁶³. Unfortunately, there is often insufficient government funding for psychiatric services, let alone culturally sensitive ones for refugees⁷⁶⁴. Yet, one can start through raising awareness and training health providers at every level about the cultural and religious characteristics of refugee communities which can affect access and treatment⁷⁶⁵. Finally, in order to address gender disparities in access, refugee communities must be made aware that not only are women equally entitled to access services, but ensuring their access to treatment will be beneficial for the families and the broader refugee community.

2.5. Theme Five: Work and Childcare Responsibilities

The primary focus and priority of many refugee mothers in the Cape is trying to meet the survival needs of their families⁷⁶⁶. Work and childcare responsibilities are prioritised over mental health care⁷⁶⁷. This priority is understandable as in Cape Town many refugee mothers are very poor and are not entitled to childcare grants. However, there can be severe repercussions in not accessing psychiatric care, both for them and for their children.

2.5.1. Work

‘I think the Department of Home Affairs could be a little bit more helpful.’ (Bernice)

758 OHCHR op cit note 697.

759 Ibid.

760 UNDP op cit note 705 at 10.

761 Jagoda et al op cit note 577.

762 Ibid.

763 Kinzie op cit note 6; also see OHCHR op cit note 697; also see CAMH op cit note 58.

764 Kinzie op cit note 6.

765 Jagoda et al op cit note 577; also see Law et al op cit note 202; also see CAMH op cit note 58.

766 Warner & Finchilescu op cit note 722.

767 Fuller op cit note 18.

An issue which was raised in the findings was that it is difficult to address mental health problems if survival needs (i.e. provision of food, shelter and clothing) have not been addressed. Finding work is a top priority for ensuring survival.

Documentation barriers need to be addressed as lack of asylum seeker or refugee permits bar refugee women from formal sector employment which is more favourable than informal sector work⁷⁶⁸. Refugee and asylum seeker women working in the formal sector are protected under the Labour Relations Act 66 of 1995 and Basic Conditions of Employment Act (BCEA) of 1997⁷⁶⁹. Under the BCEA they are entitled to take sick leave in order to access necessary mental health care⁷⁷⁰. Unfortunately, some refugee women are unaware of these benefits and may fear taking time off work for psychiatric appointments.

While they are under protective laws in the formal sector many female refugees in SA work in the informal sector⁷⁷¹ and therefore do not enjoy the rights and protections of the SA Labour Law, such as taking sick leave to access treatment⁷⁷². A high percentage of them are self-employed and therefore feel the added burden not to take time off work⁷⁷³.

Refugees with disabilities, including psychiatric disabilities, are allowed to access disability grants if they cannot work⁷⁷⁴. However, this does not apply to asylum seekers⁷⁷⁵. Unfortunately, it is becoming increasingly difficult for asylum seekers to get refugee status in SA⁷⁷⁶. As a result, many of them prioritise work over attending psychiatric appointments, with some continuing to work until they have a breakdown or are dismissed because of poor functioning.

Delays at Department of Home Affairs in documentation processing and status determination must be addressed to enable refugee women to find work in the formal

768 CTRC 'Employment' (2008) *CTRC Refugee Information Guide*, available at <http://www.ctrc.co.za/upload/Employment.pdf>

769 Ibid; also see Tara Polzer 'Migrant Employment in South Africa: New Data from the Migrant Rights Monitoring Project' (2008) *Forced Migration Studies Programme*, available at http://www.academia.edu/178134/Migrant_Employment_in_South_Africa_New_Data_from_the_Migrant_Rights_Monitoring_Project.

770 s22-24 of the Basic Conditions of Employment Act of 1997; also see CTRC op cit note 768.

771 'Informal sector refers to 'all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements' Anne Trebilcock 'International labour standards and the informal economy' *International Labour Organization (ILO) Standards and the Informal Economy*, available at http://www.ilo.int/wcmsp5/groups/public/---dgreports/---integration/documents/publication/wcms_079256.pdf.

772 Murray Leibrandt, Ingrid Woolard & Hayley McEwen *et al.* 'Employment and Inequality outcomes in South Africa' *Southern Africa Labour and Development Research Unit (SALDRU) & School of Economics, University of Cape Town*, available at <http://www.oecd.org/els/employmentpoliciesanddata/45282868.pdf>; also see Polzer op cit note 769.

773 Polzer op cit note 769.

774 CTRC op cit note 609.

775 Ibid.

776 CoRMSA op cit note 179; also see Vigneswaran op cit note 179; also see IRIN op cit note 132; also see Amisi & Ballard op cit note 410.

sector or to access disability grants (for those who are too ill to work). Furthermore, there should be increased networking between mental health providers and NGOs providing skills-development, so that the multiple needs of refugee women are holistically addressed⁷⁷⁷.

2.5.2. Childcare Responsibilities

The responsibility of children is a significant barrier for refugee women seeking psychiatric help⁷⁷⁸. A possible means to overcome this 'childcare barrier' would be for government to provide subsidised childcare services for refugees. However, many South Africans who are similarly destitute do not enjoy subsidised childcare and thus it would be unreasonable to provide special treatment for refugees over citizens⁷⁷⁹. Nevertheless, this is a significant barrier which requires targeted intervention.

2.6. Theme Six: Individual Barriers

2.6.1. Fear of Shame and Rejection

Many of the female refugees that were seen had experienced sexual violence. This is consistent with the UNHCR findings which show that approximately 80% of all refugee women have experienced some form of sexual assault⁷⁸⁰. Shame and fear of rejection causes many of them to remain silent about their trauma and refrain from seeking treatment⁷⁸¹.

777 UNHCR 'Handicrafts of hope for refugee women in South Africa' (27 September 2002), available at <http://www.unhcr.org/3d9459314.html>.

778 Refugee Council op cit note 569; also see Centers for Disease Control and Prevention 'Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs That Provide Services to Persons from Somalia' (2008) Atlanta, GA: U.S. Department of Health and Human Services, available at <http://www.cdc.gov/tb/publications/guidetoolkits/EthnographicGuides/Somalia/chapters/SomaliTBBooklet.pdf>; also see Warner & Finchilescu op cit note 722; also see Johnson op cit note 489; also see Lauren op cit note 399; also see Rebecca op cit note 399; also see Doctors Without Borders 'Mental Healthcare in Kashmir, DRC, and Iraq' 14 October 2010, available at <http://www.doctorswithoutborders.org/news/article.cfm?id=4801&cat=field-news>; also see Levers et al op cit note 746.

779 CTRC 'Education' *CTRC Refugee Information Guide*, available at <http://www.ctrcc.co.za/upload/Education.pdf>

780 Julie Savage & Rise Becker 'Refugee Women, Sexual Assault, and Communities' (2003) presented by Julie Savage at "Practice and Prevention: Contemporary Issues in Adult Sexual Assault in New South Wales Conference", University of Technology, Sydney (12-14 February 2003), available at <http://www.startts.org.au/media/Research-Doc-Refugee-women-sexual-assault-and-communities.pdf>.

781 Giroin et al op cit note 284; also see Marcel op cit note 399; also see Rebecca op cit note 399; also see also see Morgan op cit note 399; also see Wolfe op cit note 142.

In Somali culture it is particularly shameful to discuss issues of sexuality and females who have been raped are encouraged to remain silent about their assault⁷⁸². This could be influenced by their religious beliefs, as studies amongst other Muslim refugee women have shown that they are particularly reticent to open up about sexual trauma, with some committing suicide rather than living with the shame⁷⁸³.

In order to overcome this barrier it is vital to collaborate with community leaders to address the damaging cultural norms which shame and ostracise psychiatrically ill individuals and victims of sexual assault⁷⁸⁴. These communities need to be made aware that sexual violence constitutes a human rights abuse and that victims should be treated with respect and care rather than discrimination and rejection⁷⁸⁵. Women's rights need to be promoted in a culturally sensitive manner⁷⁸⁶. Effectively addressing harmful cultural attitudes and practices requires careful, sensitive collaboration with refugee community leaders⁷⁸⁷. However, addressing destructive cultural norms takes time⁷⁸⁸.

2.6.2. Fear of Facing Past Traumas

Many female refugees are wary of accessing services because they fear facing past traumas⁷⁸⁹. They try to block out traumatic experiences in order to cope⁷⁹⁰. For those who do seek treatment many take a long time to open up owing to shame, lack of trust and unfamiliarity with counselling⁷⁹¹. Unfortunately, mental health workers in the Cape often lack time for the long-term, intensive treatment traumatised refugees require⁷⁹². This fear of opening up as well as the limited availability of long term treatment is problematic as untreated or insufficiently treated trauma conditions can severely affect functioning and prognosis⁷⁹³.

782 Bokore op cit note 754; also see Jagoda et al op cit note 577.

783 Savage & Becker op cit note 780.

784 CAMH op cit note 58; also see Johnson op cit note 489; also see CEDAW of 1979 General Recommendation No. 3 (1987).

785 Wolfe op cit note 142; also see Human Rights Watch 'Struggling to Survive: Barriers to Justice for Rape Victims in Rwanda' 30 September 2004, available at <http://www.unhcr.org/refworld/docid/42c3bd2b0.html>.

786 United Nations Population Fund (UNFP) 'Using Culturally Sensitive Approaches: Promoting Human Rights through Culturally Sensitive Approaches' (2009) *Integrating Culture, Gender and Human Rights*, available at <http://www.unfpa.org/culture/rights.htm>.

787 Lauren Hersh 'Giving up Harmful Practices, Not Culture' *Advocates for Youth* February 1998, available at <http://www.advocatesforyouth.org/publications/521?task=view>.

788 Ibid.

789 Mehraby op cit note 58.

790 Savage & Becker op cit note 780.

791 Mehraby op cit note 58.

792 Rebecca op cit note 399; also see Mpho op cit note 403; also see Josephine op cit note 400.

793 Romi Sigsworth 'Double Jeopardy: Foreign and Female' (2010) *Heinrich Boll Stiftung Policy Brief*, available at [http://www.za.boell.org/downloads/Romi_Sigsworth_\(2\).pdf](http://www.za.boell.org/downloads/Romi_Sigsworth_(2).pdf); also see Savage & Becker op cit note 780; also see Johnson op cit note 489.

This fear can be addressed through increasing refugees' understanding of the impact of trauma on well-being and increasing awareness of the benefits of counselling⁷⁹⁴. Refugees must be informed that their psychological responses to trauma are normal and that they are not alone in experiencing such symptoms⁷⁹⁵. Health providers and refugee workers should be informed of the high prevalence of traumatic experiences amongst female refugees⁷⁹⁶. They should be particularly alert to signs of distress and actively refer and encourage refugees to access counselling⁷⁹⁷. Finally, the government should increase the capacity of the mental health sector to better meet the long-term mental health needs of refugees.

2.6.3. Lack of Insight into their Condition and Need for Treatment

Another big barrier was psychiatrically ill refugees' lack of insight into their condition and the impact this was having on their functioning. It is common for people with psychiatric conditions to lack insight into their mental illness⁷⁹⁸. However, this is exacerbated amongst refugees as in many of their cultures mental illness is poorly understood⁷⁹⁹. This lack of insight is more problematic where mental illness is less severe⁸⁰⁰. When an individual is dangerously psychotic their diagnosis will be more easily identifiable by the community and the police will be able to take them directly to a hospital⁸⁰¹.

Unfortunately, increasing a mentally ill person's insight into their illness and need for treatment is not easy⁸⁰². However, it can be partially addressed through conducting awareness-raising in refugee communities on the topics of mental illness and the benefits of treatment⁸⁰³.

794 Mehraby op cit note 58; also see Rebecca op cit note 399; also see also see Morgan op cit note 399; also see Marcel op cit note 399; also see Mpho op cit note 403; also see Josephine op cit note 400; also see Johnson op cit note 489.

795 Johnson op cit note 489.

796 Ibid; also see N Merhaby 2001 in Savage & Becker op cit note 780.

797 Savage & Becker op cit note 780; also see Johnson op cit note 489.

798 E. Fuller Torrey 'Impaired awareness of illness: Anosognosia' (2011), available at <http://mentallinesspolicy.org/medical/anosognosia-studies.html>.

799 Savage & Becker op cit note 780; also see Rebecca op cit note 399 at 4; also see Marcel op cit note 399; also see Sarah op cit note 399; also see Morgan op cit note 399; also see Johnson op cit note 489.

800 Jagoda et al op cit note 577.

801 Mental Health Care Act 17 of 2002.

802 Fuller Torrey op cit note 798.

803 Johnson op cit note 489.

2.6.4. Lack of Awareness of Available Services or how to Navigate Services

2.6.4.1. Lack of Awareness of Available Services

In SA ‘word of mouth’ is a common way for refugees to learn about psychiatric or counselling services. Unfortunately, owing to mistrust many refugees isolate themselves and are less aware of available services.

The right to health includes awareness of available services (information accessibility)⁸⁰⁴. Lack of awareness impinges on this right. To overcome this barrier, refugee communities must be made aware of their right to access mental health services; the importance of exercising this right and where they can access such services⁸⁰⁵.

Ideally, regular psychiatric screening clinics should be conducted in communities throughout the Cape. Unfortunately, very few outreach clinics are conducted by mental health facilities in SA⁸⁰⁶. Lack of resources, time and danger pose a barrier to psychiatric screening and outreach clinics⁸⁰⁷. Mpho mentioned how she had been hijacked on a psychiatric community outreach and as a result is wary of doing future outreaches. Many nurses are struggling to cope with their client load, let alone seek out undiagnosed individuals. Another way to achieve this right would be to conduct routine health (including mental health) screenings of refugees as they enter the country⁸⁰⁸.

2.6.4.2. Difficulty in Navigating Available Services

Many refugee clients find it difficult to navigate services particularly at hospitals. When they have anxiety or depression or struggle to speak the language, the experience of trying to navigate the system and of sitting in overcrowded waiting rooms can be overwhelming⁸⁰⁹. As a result many are wary of accessing these services⁸¹⁰.

The right to health includes the right to accessible health services⁸¹¹. Psychiatric services can be made more accessible to refugees by ensuring that signs and posters in

804 Leslie London, Nicolé Fick, Khai Hoan Tram ‘Filling the gap: A Learning Network for Health and Human Rights in the Western Cape, South Africa’ (2012) 14 (1) *Health and Human Rights Journal*, available at <http://www.hhrjournal.org/index.php/hhr/article/view/452/768>; also see OHCHR op cit note 697.

805 SAFMH ‘April 2010-March 2011: Annual Report SA Federation for Mental Health’ (2011), available at <http://www.safmh.org.za/Images/AnnRep11.pdf>.

806 WHO op cit note 235.

807 Ibid.

808 CAMH op cit note 58.

809 Ilondo op cit note 325.

810 Ibid.

811 London et al op cit note 813.

hospitals are translated into the common refugee languages⁸¹². Furthermore, clerks should be made aware of the difficulties faced by refugees in accessing health services and should be trained to provide special assistance for them.

3. Strengths and Limitations

3.1. Strengths

I will now highlight some of the main strengths of this study. First, the study addressed a topic upon which very little has been written and thus filled a knowledge gap. Secondly, as an empirical study, it gathered new data particularly relevant to refugees in the Cape Metropole. Thirdly, the participants came from a range of institutions across the Cape, both public and NGO. This added diversity to the data. Fourthly, a number of the participants had worked with many refugees and findings were comprehensive. Finally, the use of semi-structured in-depth interviewing allowed for the participants' lived experiences to be reflected in the data.

3.2. Limitations

The first limitation of this study was that the sample did not include participants from secondary hospitals. This limited the diversity of findings. A second limitation was not interviewing refugees themselves. I refrained from interviewing them for ethical reasons and because of language difficulties. However, if I had interviewed them I could have gained insight into barriers which service providers were unaware of. In future, it would be helpful to expand this study and use a mixed Qualitative and Quantitative study design. One could interview both mental health providers and psychiatrically ill female refugees to provide a broader understanding of the study phenomenon. This would require extensive time and use of stringent ethical measures to ensure the well-being of refugee participants was upheld.

812 CoRMSA op cit note 179.

CHAPTER 6: CONCLUSION

...Compounded and/or buried trauma does not disappear, and can dramatically affect the functioning of an individual, causing dissociative episodes, uncontainable emotions, self-destructive behaviour and an altered view [of] the world, among other symptoms. As such, the experience of trauma is an everyday reality for migrant women living in South Africa because it not only exists in the past, but old and new forms of trauma still persist as a part of their daily lives...⁸¹³

As highlighted throughout this study many of the female refugees living in the Cape Metropole have experienced a number of traumatic experiences pre-migration, during migration and post-migration. As a result many suffer from severe psychological and psychiatric disorders or battle a profound sense of loss⁸¹⁴. Despite this high prevalence of trauma there is low psychiatric service utilization amongst this population owing to various barriers to access. It is suspected that there are many female refugees in the Cape suffering untreated mental health disorders. Not only does this untreated psychiatric illness cause immense personal suffering but it has a debilitating impact on functioning. This in turn affects to a greater or lesser extent the refugees' families, communities and the broader South African society.

This chapter will conclude the study by outlining how study findings have answered the question '*What are the barriers to access to mental health care services in the Cape faced by refugee and asylum seeker women who have been exposed to trauma?*'

Through use of a phenomenological design this empirical study aimed to investigate the thesis question. Chapter One introduced and contextualized the research question. It further outlined legislation and policies which identify the right of female refugees in the Cape to access mental health services and highlighted the human rights nature of this topic. In Chapter Two the prevalence of mental illness amongst refugees and the traumatic experiences many of them face both globally and in SA was discussed. This led to discussion on mental illness in SA, and in particular the Western Cape, and the legislation and policies governing psychiatric service delivery. Finally, the main barriers to mental health services globally were discussed and compared to literature on barriers to health services in SA. Chapter Three on Methodology outlined the study process, how it evolved and the ethical measures which were put in place. Chapter Four identified the findings and provided a contextual background to the refugees seen by the participants. It described the

813 Sigsworth op cit note 793.

814 R.Srinivasamurthy & Rashmi Lakshminarayana 'Mental health consequences of war: a brief review of research findings' (2006) 5(1) *World Psychiatry* 25–30, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472271/>.

main themes (barriers) as perceived by participants. Chapter Five then discussed these themes in relation to the thesis question and objectives.

Generally the findings supported the study hypothesis that more male refugees were accessing psychiatric services than females. While it was not always clear why this was the case certain barriers were suggested. Most of these barriers were consistent with those faced by refugees globally as identified by the literature, while others were particularly an issue in the Cape. Findings showed that barriers occurred both at the service delivery level and within the refugee communities. As this is a qualitative study it is difficult to quantify the extent to which each barrier affected access, but some barriers did appear to be more of an issue. Generally, laws and policies in SA are progressive and provide refugees with comprehensive rights. However, barriers were found in the implementation of these laws. Other ‘supply-side’ barriers included: lack of understanding of refugees’ rights; xenophobia; over-burdened staff and under-resourced services. Issues of language and transport were raised, with many perceiving language to be the greatest barrier to access. The ‘demand-side’ barriers included: culture and religion, and work and childcare responsibilities. Lack of insight and fear of shame and stigma were also highlighted. The extent to which each is a barrier will partly depend on the service providers, as well as the individuals and the communities they come from.

Finally, the right to mental health care includes the right to accessible mental health services⁸¹⁵. Through this study various barriers have emerged which prevent female refugees in the Cape from enjoying this right. Some of these barriers are more complex to address than others, but I would argue that all of them are remediable. The government is obliged to take measures to ensure that this right is progressively realised. The state’s failure to adequately address this right not only violates its’ obligations under IHRL but it perpetuates the suffering of an incredibly vulnerable population group⁸¹⁶. The impact that refugees’ untreated mental health conditions will have on the larger South African society cannot be ignored. This is illustrated in the quote of Dr Manuel Carballo (Director of the Geneva-based International Centre for Migration Health and Development):

‘[Refugees] can very quickly fall through the cracks and be forgotten...But there can only be so many people suffering...before it starts to become contagious to the larger society⁸¹⁷.’

815 OHCHR op cit note 697.

816 Ibid.

817 IRIN op cit note 5.

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APPENDIX A: EMAIL TEMPLATE FOR GATEKEEPER

Dear

I hope this email finds you well. By way of introduction, my name is Giselle Warton and I am currently doing an MPhil in Social Justice at UCT. I am interested in doing my dissertation on the right to access to mental health care of female refugees, more specifically looking at:

‘What are the barriers to access to mental health care services in the Cape Metropole, faced by refugee and asylum seeker women who have been exposed to trauma?’

The research will entail conducting semi-structured interviews with one or two members of your organization who have had experience in working with traumatised female refugees (The trauma may have occurred in their home country, en route to South Africa or in South Africa). The interview will be at least 60 minutes long, and if you are willing it will be conducted in private at your organization. This may be followed, at a later stage, by a focus group consisting of your two members and mental health care workers from three other organizations. The focus group will be run if your organization and the other participant organizations think that it would be feasible and beneficial. I have approached your organization, as owing to your experience of working with refugees with mental health conditions I believe that you could contribute valuable information to my research. I have attached a copy of my research information sheet, so that you can have a more comprehensive understanding of what the research entails. I am planning on conducting these interviews and the focus group (if it is conducted) in October 2012. Details about member-checking, anonymity and confidentiality are contained in the attached information sheet.

Warm regards,

Giselle Warton



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APPENDIX B - INFORMATION SHEET FOR INTERVIEWS

BARRIERS TO ACCESS TO MENTAL HEALTH CARE SERVICES IN THE CAPE METROPOLE, FACED BY REFUGEE AND ASYLUM SEEKER WOMEN WHO HAVE BEEN EXPOSED TO TRAUMA

Hello, my name is Giselle Warton and I am a Masters student from the University of Cape Town. I am conducting research in order to fulfil requirements for my degree. I am inviting you to take part in my research study which is investigating the barriers to access to mental health care services in the Cape Metropole faced by female refugees who have been exposed to trauma.

Exploring perceptions of barriers to access to mental health care services faced by female refugees in the Cape Metropole

This research involves exploring mental health care workers' perceptions of the barriers to access to mental health care in the Cape Metropole faced by female refugees who have been exposed to trauma. I would like to interview mental health care workers at both NGOs and public health facilities in the Cape Metropole, who have had contact with traumatised female refugees to gain an understanding of what they perceive these barriers to be.

I am interested in finding out about what you perceive these barriers to be. Owing to your experience working with refugees who have been exposed to trauma, your contribution would be valuable to my research.

Please understand that you do not have to participate in this study if you do not want to. The choice to participate is yours alone. If you choose not to participate, there will be no negative consequences. If you choose to participate, but wish to withdraw at any time, you will be free to do so without negative consequences. However, I would be grateful if you would assist me by allowing me to interview you.

If you choose to participate in this study, you will be asked to participate in one 60 minute interview. The interview will be recorded with the use of a Dictaphone and this recording will be transcribed. The transcriptions will be kept on a flash-drive which is password secure. The reason that I need to use a Dictaphone is in order to ensure that all the verbal information from the interview is collected. However, if you do not feel comfortable with me recording the interview with a Dictaphone, then I will not use one and will rather take field notes during the interview. Only my supervisor and I will have access to these transcriptions and field notes.

Once I have written up the findings from this interview, I will send the write up of your section to you, so you can see whether I have accurately represented what you said. If you

are unhappy with any quotes I have included from your interview, then these can be removed.

You will not directly benefit from this research. However, this research will be used to fill a knowledge gap on this topic and the hope is that it will serve to increase understanding of the difficulties that female refugees are facing regarding mental health services. Furthermore, the hope is that through the course of this research suggestions may be generated which could improve the situation.

If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. If you are worried that by sharing this information it will negatively impact on your relationships with your organization and other stakeholders, I assure you that I will do the utmost to ensure that what you say is not misrepresented. You will have a chance to look through what is written, before the dissertation is submitted to ensure that you agree with how I have represented what you have said.

During the interview no one else will be present except for me. All the information discussed during the interview is confidential and no one except for my supervisor and me will have access to this information. If you want to remain anonymous, then I will substitute a pseudonym for your name when writing up the report.

The information you provide us with in this interview will be used to write up a report. The report will be viewed by my supervisor and another examiner. Prior to submitting this report, I will send you a copy of what I have written up on your contribution so you can decide if what you said has been accurately reported. If you feel that you have been misrepresented or inaccurately reported in any section, you will have a chance to correct this.

The transcribed and written research data from your interview will be kept on a password secure flash-drive in a safe place. Only I will know the password, and therefore no one else will have access to your transcribed interview or the field notes from your interview. If an audio recording of your interview is conducted, it will be deleted after the research is complete. The Dictaphone with the audio recordings will also be kept in a safe place.

If you consent, however, I will keep this data after completion of this research, for use in future research. If you are willing for me to use this data for additional research, then if you could provide me with your contact details I can re-contact you if needed in future, to once again ask your consent. If you do not want me to keep your contribution to the data, I will delete it after the research is complete.

'If you have concerns about the research, its risks and benefits or about your rights as a research participant in this study, you may contact the Law Faculty Research Ethics Committee Administrator, Mrs Lamize Viljoen, at 021 650 3080 or at lamize.viljoen@uct.ac.za. Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator, Room 6.28 Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 770



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APPENDIX C - INFORMATION SHEET FOR FOCUS GROUP PARTICIPANTS

BARRIERS TO ACCESS TO MENTAL HEALTH CARE SERVICES IN THE CAPE METROPOLE, FACED BY REFUGEE AND ASYLUM SEEKER WOMEN WHO HAVE BEEN EXPOSED TO TRAUMA

Hello, my name is Giselle Warton and I am a Masters student from the University of Cape Town. I am conducting research in order to fulfil requirements for my degree. I am inviting you to take part in my research study which is investigating the barriers to access to mental health care services in the Cape Metropole faced by female refugees who have been exposed to trauma.

Exploring perceptions of barriers to access to mental health care services faced by female refugees in the Cape Metropole

This research involves exploring mental health care workers' perceptions of the barriers to access to mental health care in the Cape Metropole faced by female refugees who have been exposed to trauma. Following the personal interviews I will conduct with you and other mental health care workers I may conduct a focus group with all of the participants. This will involve a one hour focus group discussion on themes related to the research question. The focus group will consist of the 7 other research participants, my co-facilitator and me. The co-facilitator and I will sign a confidentiality form to ensure that we will remain confidential regarding focus group participants and the information that is shared. You will also be requested to sign a confidentiality form, should you participate, which outlines that you will not disclose names and information that is discussed. The focus group will be recorded with the use of a Dictaphone and this recording will be transcribed. Field notes will also be taken during this meeting. The transcriptions will be kept on a flash-drive which is password secure. The reason that I need to use a Dictaphone is in order to ensure that all the verbal information from this group meeting is collected. However, if you do not feel comfortable with me recording the interview with a Dictaphone, then I will only take field notes during the group session. Only my supervisor and I will have access to these transcriptions and field notes. A possible venue for this focus group will be a room at Kramer Building, Middle Campus, UCT.

Please understand that you do not have to participate in this study if you do not want to. The choice to participate is yours alone. If you choose not to participate, there will be no negative consequences. If you choose to participate, but wish to withdraw at any time, you will be free to do so without negative consequences.

However, I would be grateful if you would assist me by being prepared to engage in this focus group discussion.

Once I have compiled the data, I will send the write up to you, so you can see whether I have accurately represented what you contributed. If you are unhappy with any of your quotes that have been used these can be removed.

You will not directly benefit from this research. However, this research will be used to fill a knowledge gap on this topic and the hope is that it will serve to increase understanding of the difficulties that female refugees are facing regarding mental health services. Furthermore, the hope is that through the course of this research suggestions may be generated which could improve the situation.

If any of the questions asked of you cause you undue distress, you do not have to answer them. Furthermore, if you are worried that by sharing this information it will negatively impact on your relationships with your organization and other stakeholders, I assure you that I will do the utmost to ensure that what you say is not misrepresented. You will have a chance to check through what is written, before the dissertation is submitted to ensure that you agree with how I have represented what you have said. If you want to remain anonymous, then I will substitute a pseudonym for your name.

The information you provide us with during this focus group will be used to write up a report. The report will be viewed by my supervisor and another examiner. Prior to submitting this report, I will send you a copy of the field notes taken during this meeting, so you can determine if what was discussed has been accurately reported. The field notes will be adapted accordingly.

'If you have concerns about the research, its risks and benefits or about your rights as a research participant in this study, you may contact the Law Faculty Research Ethics Committee Administrator, Mrs Lamize Viljoen, at 021 650 3080 or at lamize.viljoen@uct.ac.za. Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator, Room 6.28 Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 7701.



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**APPENDIX D: CERTIFICATE OF CONSENT FOR GATEKEEPER
ORGANIZATION**

My organization has been invited to participate in research regarding barriers to access to mental health care services faced by female refugees who have been exposed to trauma.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily for members of my organization to participate in this study

I want this organization to remain anonymous: Yes No

I am willing for information from these research interviews to be used for this research:

Yes No

I am willing for information from these research interviews to be used for further research:

Yes No

If yes, please provide an email address or other contact details:

Print Name of Organization Representative _____

Signature of Organization Representative _____

Date _____

FOR RESEARCHER

I have provided the representative of the organization with an information sheet concerning the proposed research:

1. The Organization Representative understands what is required of his/her members and has had all his/her questions answered.
2. The Organization Representative does not feel that the organization is forced to take part in this study.
3. The Organization Representative knows that his/her members can withdraw at any time if they want to.

Name of Researcher _____

Signature of Researcher: _____

Date _____



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APPENDIX E: CERTIFICATE OF CONSENT FOR PARTICIPANT

I have been invited to participate in research regarding barriers to access to mental health care services faced by female refugees who have been exposed to trauma.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

I want to remain anonymous: Yes No

I am willing to be recorded on a Dictaphone: Yes No

I am willing for information from my interview to be used for additional research:

Yes No

If yes, please provide an email address or other contact details:

Print Name of Participant _____

Signature of Participant _____

Date _____

FOR RESEARCHER

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. The participant understands what is required of him/her and has had all his/her questions answered.
2. The participant does not feel that he/she is forced to take part in this study and is doing so of his/her own free will.
3. The participant knows that he/she can withdraw at any time if he/she so wishes and it will have no bad consequences for him/her.

A copy of the Informed Consent Form has been provided to the participant.

Name of Researcher _____ Signature of Researcher _____

Date _____



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APPENDIX F: FOCUS GROUP CONSENT FORM FOR PARTICIPANT

I have been invited to participate in research regarding barriers to access to mental health care services faced by female refugees who have been exposed to trauma.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this focus group and in this study.

I want to remain anonymous: Yes No

I will not share the names of other participants or information discussed in this focus group:

Yes No

I am willing to be recorded on a Dictaphone: Yes No

I am willing for information from my interview to be used for additional research:

Yes No

If yes, please provide an email address or other contact details: _____

Print Name of Participant _____

Signature of Participant _____

Date _____

FOR FACILITATOR AND CO-FACILITATOR

I have provided a copy of the Informed Consent Form to the participant and made sure that the participant understands the following:

1. What is required of him/her and has had all his/her questions answered.
2. The participant does not feel that he/she is forced to take part in this study and is doing so of his/her own free will.
3. The participant knows that he/she can withdraw at any time if he/she so wishes and it will have no bad consequences for him/her.

I promise not to share the name of this participant outside of this focus group, if they wish to remain anonymous.

I promise not to share confidential information provided by this participant.

Name of Facilitator _____ Signature of Facilitator: _____

Name of Co-Facilitator _____ Signature of Co-Facilitator: _____

Date _____

APPENDIX G: SEMI-STRUCTURED INTERVIEW QUESTIONS

Please note: As this is a semi-structured interview, these questions may be expanded on during the interviews.

1. Introductory Questions

1. How long have you worked in this facility?
2. How long have you worked with female refugees in mental health care work?
3. How many refugees do you see on average per month?
4. How many female refugees do you see on average per month?
5. Do more female refugees or male refugees access your services? Why do you think this is so?
6. Into what age category do the refugees you see mainly fall into? Why do you think this is so?
7. Where are the majority of the refugees you see coming from (country of origin)?
8. From which areas in the Cape Metropole are the refugees you see, primarily coming from? Why do you think this is so?
9. What is the prevalence of exposure to trauma faced by these female refugees?
10. Is this trauma primarily experienced; prior to migration, during flight, or once in South Africa?

2. In your experience, what are the main barriers that female refugees face in accessing mental health care services?

3. Structural Barriers

3.1. Legislation and Policies

- 3.1.1. From your experience what legislation or policies could hinder female refugees accessing mental health care services in the Cape Metropole?

3.2. Service Provision

- 3.2.1. What are possible barriers in service provision which could hinder female refugees accessing mental health care services in the Cape Metropole?

3.3. Referral system

3.3.1. What has your experience been of the referral system of female refugees between primary, secondary and tertiary care?

4. Institutional Barriers

What are possible barriers within organizations offering mental health care services which could hinder female refugees from accessing these services?

5. Geographical Barriers

What would you perceive as possible geographical barriers to female refugees accessing mental health care services? (eg. Distance, no mental health service provision in their area, difficulty in referring if refugees move)

6. Barrier within the community

What would you perceive as barriers within communities which could hinder female refugees accessing mental health care services? (Eg. Gender, cultural or social barriers, xenophobia)

7. Barrier within the home

What factors within a female refugee's house-hold could serve as a barrier to her accessing mental health care provision?

8. Individual Attitudinal Barriers

What are possible individual attitudinal barriers which may hinder a female refugee accessing mental health care services?

9. Client compliance

How does compliance to medication and accessing services compare between female refugees and your other clients? Why do you think this is so?

10. What would your suggestions be as to how to overcome these barriers?

APPENDIX H: TRIGGER QUESTIONS FOR FOCUS GROUPS

Please Note: Ideally this focus group will be recorded with a Dictaphone, because although field notes will be taken, sometimes one is unable capture all that has been said through these notes. However, if anyone in the group is uncomfortable in being recorded we will not use the Dictaphone.

Themes to be covered

Below is an outline of the main themes/ issues to be covered in the focus group. However, depending on the nature of the data gathered from the in-depth interviews, additional themes may be added to this list/ or possibly some areas removed.

1. Structural Barriers
2. Institutional Barriers
3. Geographical Barriers
4. Knowledge and Attitudinal Barriers within the Community
5. Cultural Barriers within Refugee Groups
6. Barriers within the home
7. Individual attitudinal and knowledge Barriers
8. Suggestions for overcoming these barriers