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**Refugees and Public Health in the Cape Town Area:
Treating the Other**

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed and has been cited and referenced

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ABSTRACT

The main focus of my thesis is the role and the faults of the welfare system in promoting public policies for the overall wellbeing of refugees in a South African global perspective; as indicator of such a system a study of the Health Sector has been carried out. The thesis takes into account the main sociological streams developed in migration studies (Karl Marx, Max Weber, Emile Durkheim, Georg Simmel, Robert Ezra Park) and it is focused on the analysis of the more recent pattern of multiculturalism and citizenship (Loren Landau, Alessandro Dal Lago, Francesco Remotti, Jonathan Crush, Francis B. Nyamnjoh, Jeremy Waldron, Etienne Balibar, Catherine Cross); the latter used as unit of analysis to understand the perverse mechanism of inclusion/exclusion from basic necessities, such as healthcare, for citizens and non-citizens.

Methodologically I at first thought to rely on a qualitative approach by collecting 15 in-depth interviews with refugees referring to one of the main NGO's dealing with refugees' issues, and member of the Tutumike network which was ARESTA (Agency for Refugees Education, Skills Training and Advocacy). Unfortunately, during the pilot stage of the research, I became acutely aware of the serious problem that the linguistic barrier between my intended respondents and I posed, so I thought I could use the qualitative interview data I did manage to obtain to inform and design a questionnaire to be used in a quantitative study.

When I decided to focus on a quantitative approach I at first faced the sample design stage: since I could not find any official data at the Refugee Office of the Home Affairs, I decided to rely on the databases provided from four NGO's (ARESTA, Planned Parenthood Association of South Africa, Scalabrini Refugee Service and Trauma Centre). After merging the four databases and cleaning them from the repetition of names I decided to use a stratified sampling but, in order to compare refugees with different religious backgrounds, I decided to over-sample certain nationalities which were underrepresented in my sample frame, so I used a non-PPS sampling as for nationalities and PPS sampling as for gender, having a final sample size of 762 respondents.

As far as the questionnaire is concerned I designed a battery of questions which included dichotomous questions, open-ended questions and multiple choice questions. I used SPSS for the analysis which was focused on univariate statistics and bivariate statistics. As far

as the tests are concerned I decided to rely on the correlation coefficient Cramer's V and Eta as the Pearson's X^2 is simply an index that provides a succinct description of the extent and character of the relationship between two variables.

The questionnaire was administered telephonically by the ARESTA's team which I trained for such a task.

As far as the findings are concerned I can say that the linguistic barrier and the problems related to the recognition of the asylum seeker permit and the Refugee Status seem to be the major obstacles which refugees experience in South Africa; moreover such problems affect refugees in accessing the labour market: refugees seem to be arriving with high educational levels in the Country but they are encapsulated in elementary occupations with no training and lower monthly income in comparison to the rest of the South African population. On the other side the lack of education on refugees' issues from the Health Department result in an unjustified rejection of refugees from healthcare institutions. NGO's are trying to overcome the problem by running workshops which inform hospital staff on refugees' matters. The main problem related to the recognition of documents seems to be more serious for those respondents who declare to only have an Appointment slip which does not have any legal value and which force them on relying on a very expensive private sector not easily affordable.

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INTRODUCTION

This study presents the results of research on migrants and refugees in contemporary South Africa and the main problems they face in accessing public institutions. The will to carry on with such a topic arose when I started my collaboration with ARESTA (Agency for Refugee Education, Skills Training and Advocacy) and I noted how problems related to the permits could actually affect and shape refugees' lives: the long process which refugees undertake to obtain one of two statuses (Asylum permit or Refugee status) puts them in a position of extreme vulnerability which reflects the high percentage of respondents who experience, or experienced, rejection within public health institutions. The problem becomes even more serious for those refugees whose interviews¹ are still pending and who can not benefit from accessing physicians as they only have an Appointment slip which, until November 2007, did not have any legal recognition within public institutions; so I assumed that the issues surrounding the delays within the Department of Home Affairs, which refugees and NGO's complained about, leave refugees in a limbo borne from exclusion and shape their lives on different aspects included healthcare, and the results of my analysis will show that those respondents whose status was not granted yet never went to visit a doctor despite their need.

The aims of the study are essentially four: first to show structural similarities between the refugee population and the population of economic migrants; second to validate the theoretical model linked to the concept of citizenship as the category which draws the line between *insiders* and *outsiders* in South Africa, third to highlight a model of multiculturalism which is based on division rather than integration; and finally, linked to the second and the third aims, to show in a descriptive way which problems refugees are actually facing within healthcare institutions as a result of the ideology of citizenship and multiculturalism adopted in South Africa.

As far as the first aim is concerned, on the one hand, I focused my attention on reading a wide literature on migration studies and I found interesting Hein's (1993) assumptions about the importance of demographic variables (e.g. Gender, age, education, occupation and income) which reveal the similar backgrounds of refugees and economic migrants,

¹ The interview regards the legal process at the Refugee Office of the Department of Home Affairs to be granted with the Asylum Seeker permit (S.22) or the Refugee Status (S.24)

groups which often have been treated as two separate objects of study. When I constructed my questionnaire I kept this similarity in mind and focussed the first part of the questionnaire on such variables. In Chapter 5 I will present different tables which will show the extent of these similarities in the sample group I studied. On the other hand, push and pull theories, as we will see in the next chapter (Ch. 3), are easily applicable to refugees studies as refugees had to leave their countries to escape persecution, imprisonment, torture or even death and they show a rational choice, in choosing the country of destination, which is dictated from seeking a life-improvement, and while collecting the in-depth interviews I tried to investigate the reasons of moving and the pieces of interviews I will report in chapter 3 will show this feature.

As far as the second aim is concerned, this study examines the role of South Africa as a host society. Starting from Sayad's point of view, the role of migrants is seen as a *mirror-function* (in Dal Lago 2005:205) of all phenomena of migration; in other words migrants, just because they live among *us*, are the ones who force us to reveal who we are (as a society), so that migration, more than any other phenomenon, is able to reveal our true nature and that of our society: when we talk about migration we talk about *us* in relation to *them*. Relying on Nyamnjoh (2006), Dal Lago (2005), Heisler (1992), Fleiner (1994), and thanks to the analysis rising from my data, I wanted to emphasize the concept of citizenship as an analytic category which includes or excludes people from benefiting from basic public amenities. In order to better understand the characteristic of South Africa as a host society I focused my attention on the situation of refugees' access to healthcare, treated, in the present work, as an indicator of how the South African welfare system copes in response to the massive waves of refugees coming from different African countries with different social and cultural backgrounds.

As far as the third aim is concerned, as I will discuss in the next chapter, the expression of multiculturalism in South Africa has been, and is still one of division (Bekker & Leilde 2004), which creates deep lines of inequity and therefore a high potential for violence inside the society. Along with the model of multiculturalism, new forms of politics of identity and belonging are rising which isolate refugees into the concept / category of "Makwerekwere". This concept summarizes the struggle undertaken by these particular kind of migrants and refugees, who are actually not formally represented, and appears to

strengthen the inclusion and recognition of some (South African citizens) and the inevitable exclusion, lack of recognition and explicit non-belonging of the other: a social and political position which reflects not only the challenges faced within healthcare, but also the unskilled labour sector that refugees unwillingly monopolize in spite of their higher levels of education (Ch. 5).

As far as the fourth aim is concerned, I noted in literature (JICA, UNHCR, CASE 2003; Chiranjan, Egan, Gibson, Samsodien 2005) that despite having similar basic health requirements to the inhabitants of their host countries there are issues that relate more specifically to refugees such as language barriers which give refugees the impression of not being treated fairly or properly understood, xenophobia, lack of recognition of documents and lack of knowledge with regards to the workings of the National Health Care Sector which can be easily read as a form of social exclusion which refugees face. NGOs dealing with refugees complain about a lack of education and sensitivity towards refugee issues which result in unfair rejection from healthcare facilities. Factors such as these make refugees vulnerable to psychological distress and disorders. At the end of my study we will see that things have not changed in the last two years since the UCT study on refugees' healthcare needs was conducted (Chiranjan, Egan, Gibson, Samsodien 2005): language barriers are still very problematic and it is still an issue which gives refugees a sense of frustration and a feeling of rejection.

As far as methodological issues are concerned, I first attempted to use a qualitative data approach by collecting 25 in-depth interviews at ARESTA (Agency for Refugee Education, Skills Training and Advocacy) in Cape Town as I thought that a qualitative method was the best way to give voice to those who are formally excluded from public speech. However, due to severe language problems, I was forced to redesign the research project and adopt a quantitative design. This involved conducting a survey using a questionnaire partly derived from data and experience I obtained from the abandoned qualitative study. The lack of official data on the refugee population in Cape Town at the Refugee Office of Home Affairs led me to use the databases of four organizations (ARESTA, PPASA², Trauma Centre, and Scalabrini Refugee Service) to draw a sample

² PPASA: Planned Parenthood Association of South Africa

in order to conduct the survey which took place in the period July/August 2007 with 729 refugees.

The presentation, analysis and discussion of the data obtained constitute the core of this dissertation.

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1. SOCIOLOGY OF MIGRATIONS: *A MULTICULTURAL APPROACH IN A GLOBAL SOUTH AFRICA*

1.0. *Introduction*

Before focusing on refugees in the South African context, I want to discuss those groups of theories and theorists that have contributed to understanding migration issues. Migration flows, and those terms which identify them, only started to be the object of scientific observation from the nineteenth century onwards. Current migration typologies reveal migration's double feature, the economic, not very different from one century ago, and the relatively new one of the refugees which, in the 2000 UNHCR report, represents 9% of the global migration movement worldwide. There is an essential difference between 'refugee' and 'immigrant'. The refugee was, traditionally defined as a person with a well-founded fear of persecution – because of racial or ethnic background and/or religious or political beliefs. The refugee is *forced* to leave or flee because of the fear or reality of persecution, oppression, imprisonment, torture or annihilation, or due to war and its atrocities. Family members may be forced to leave or flee with the person, sometimes before or afterwards. The refugee and family do not want to leave their homeland, and cannot return to it. Sometimes, family members can return, but it would mean separation from each other. The immigrant, on the other hand, has left his/her native land *voluntarily* to come to another country, and can return to it. The reasons may be personal or economic, or result from natural disasters. He/she can be escaping from severe poverty, oppression and abuse within the family or society. The immigrant is an individual in search of an improved life; but nevertheless, traditional migration theories such as *push and pull* theories are easy to apply to refugee studies: the specific case of asylum seeking recalls the association between push factors (linked to forced situations of flight due to conditions associated with poverty and wars), and pull factors (of attraction towards better conditions and determined on a base of rational choices made relatively freely).

If we follow what Heisler (1992:623-645) wrote, we can actually divide the sociology of migration into three conventional periods. The first is a 'classic period' between 1900 and

1969 in which migration was observed and studied according to push and pull theories and assimilation patterns. The second is a 'modern period' between the 1970's and 1980's, which saw the development of structuralist and neo-Marxist theories. The third is the *contemporary period* (in the 1990's), which is characterized by the concept of multiculturalism and is focused on social movements and citizenship, a pattern which assists in the growth of new patterns of identities and the greater role played by the concept of culture in a globalized world.

As Landau (2004: 2-3) underlines, *South Africa's reintegration into the regional and global economy has been accompanied by an increase of migration and immigration into the country's urban centers. While politicians and business leaders applaud South Africa's new cosmopolitanism, conflicts over rights to space, services, and livelihoods are emerging as South Africans and African immigrants move to the streets of previously 'forbidden' cities. Encouraged by presumed links between a significant foreigner presence and many of the country's social ills—disease (HIV-AIDS especially), unemployment, and crime—South Africans are increasingly invoking nationalist rhetoric in their efforts to resolve these disputes.*

Political debates and strategy challenges associated with immigration are guiding to a reassessment of national identities. Focusing on these public debates reveals much about the quality of a country's democracy, but may ignore an additional set of informal reactions and quotidian practices that marginalize immigrants and other vulnerable groups. Not only are xenophobic violence and other forms of discrimination significant in their own right, but they have broader implications for efforts to achieve the kind of public security and administrative rationality necessary for an effective democracy. Exploring these practices is particularly important in countries which are themselves going through significant institutional and economic transformation. Indeed, while South Africa celebrates its 14th year of democracy, official and popular responses to immigration are testing its commitment to tolerance and the rule of law.

As Arendt (in Landau 2004:2) suggests, *the implications of such struggles extend beyond migrants' welfare and the definition of social or political membership to speak to the nature of state sovereignty and South Africa's young democracy.*

The present chapter has been divided into four sections; the first three sections discuss the different stages and periods of the sociology of migration, attempting to provide an overall theoretical framework; the fourth section will provide a description of the concept of identity in relation to a multicultural perspective which shapes migrants and refugees in relation to the host country, and aims to analyse the South African context, linked to a multicultural perspective of society.

1.1. *Classical Approaches*

This section will focus on classical approaches to migration studies, particularly on those of Karl Marx, Ernst Ravenstein, Emile Durkheim, Max Weber, Georg Simmel, the Chicago School and Robert Ezra Park. Before analysing these approaches one by one, it should be noted that all the approaches are mainly focused on economical reasons for migration. It is useful to remember that Marx and Durkheim played an important role in the theorization of what R.E. Park called the 'system of integration', based on the push and pull theory on the one hand, and assimilation on the other.'

Karl Marx's analysis of migration is considered very influential and it has focused essentially on the socio-economic sphere (Pollini, Scida' 2002). This approach is mainly focused on the analysis of the emigratory movement rather than the migratory one, and particularly on the phenomena of forced emigration. Marxism (Warren, 1980; Rosenberg 1994; Gramsci 1971; Cox 1994) distinguished between the forced emigration of ancient societies and the forced emigration of modern societies. The former was an answer to the strong pressure of population, which was progressively growing numerically. The latter sees productive forces as putting pressure on the population and expelling the surplus through hunger and emigration. The approach described by Marx is a typical process of internal emigration from rural areas to urban settlements. The cause is within the economical sphere of the capitalist social organization which, in its dynamics, produces impoverishment and unemployment of the labour-force, and produces a reserve industrial army of available labour.

In his approach, Marx recognises how migrations are a source of wealth but can also have negative human and social impacts.

Migrants influence the relation between base and superstructure, a metaphor which expresses the idea that the totality of relations among people, with regard to the social production of their existence, forms the economic base on which a superstructure of political and legal institutions arises. The base is associated with social consciousness, which includes religious and philosophical ideas, which do have influence on the superstructure. A conflict between the development of material productive forces and the relations of production causes social revolutions, and the resulting change in the economic base sooner or later leads to the transformation of the superstructure. According to Marx this relationship is not a one way process - it is reflexive; the base determines the superstructure in the first instance and remains the foundation of a form of social organization which then can act upon both parts of the base-superstructure metaphor. The relationship between superstructure and base is considered to be dialectic, and not a distinction between actual entities.

A second approach, close to the evolutionist stream, is the socio-geographical pattern discussed by Ravenstein (Pollini, Scida' 2002). It was then re-evaluated by Gordon, and focused on the individuation of *laws of migration* (Pollini, Scida' 2002). Ravenstein's generalizations refer to internal migration, and are based on seven universal patterns:

1. Migration streams, usually of short range, go toward urban and industrial settlements;
2. Inhabitants of a village next to a town in rapid growth move to the town. The resulting emptiness in the village area gives a chance to those migrants coming from remote areas to move into the village. This results in the amount of migrants in a particular settlement growing in an inverse proportional way to the distance from their country of origin;
3. The process of dispersion is inverse of the process of absorbing;
4. Any migratory stream produces a counter-current which compensates the former;
5. Migrants coming from remote areas tend to move into business and industrial areas;
6. Town populations are less inclined to migrate;
7. Females are more inclined to migrate than males.

Even though Ravenstein had the pattern of rural-urban migrations in mind, and not international migrations, it is important to recognize the role played by national borders in their administrative restrictions which was actually taken out from Ravenstein's theory and such a mistake led the author to admit that international migrations were ruled by those internal migrations highlighted above (Pollini, Scida' 2002).

A third approach is the one described by Durkheim (in Pollini, Scida' 2002) who has considered migratory phenomena being linked to the social morphology and not as social facts *strictu sensu*. Durkheim proposes that Sociology is made up of social morphology, social physiology and general sociology. Social physiology analyses institutions, and general sociology analyses collective representations. Social morphology is seen as a science - both descriptive and explicative - which aims to study the *sub-stratum* on which social life is based. Such a sub-stratum includes the features of the territory occupied by a certain population; the volume, the density and spatial distribution, the means of transport, the network of communications, and the width and the structure of human settlements. In his perspective, migration involves sociology as it produces both direct and indirect effects on all social and collective phenomena, and consequently on psychic-individual phenomena. The socio-morphologic approach in particular establishes a "law" of migration defined as *mechanic law of social equilibrium* which defines the necessity of the stronger population to incorporate the weaker one, and the pattern of movement being from more to less dense settlements. As a social effect migration tends to provoke the melting, on a cultural base, of populations as they lose their original differences.

A fourth approach is described by Simmel and defined as *formal sociology* (in Pollini, Scida' 2002). In this approach the author outlines the sociology of migration as focusing on the concept of the *stranger*, a sociological form which comes today and stays tomorrow. The stranger is in itself a mobile and sedentary feature, and has a specific role in social relations. It has a duality of social belongings, one coming from the country of origin and one gained within the host country. The condition of being a stranger is thus characterized either by an extreme distance or by an extreme proximity to the social circle in the host society. Such a duality is characterized, in turn, by the objectivity of the

stranger which, according to Simmel, coincides with a full participation within the host society. This can be considered a 'double weapon', as it creates a stereotype of the stranger, with the above-mentioned characteristics, *and* an individual with particular characteristics, as all the above mentioned characteristics of the stranger are able to create a perception of a stranger as a particular type rather than an individual with particular characteristics.

The fifth perspective in this section concerns Max Weber's sociology, and his sociology of migration. This is outlined in two important essays. The first one was written in 1892 and titled *Die Verhältnisse der Landarbeiter im ostelbischen Deutschland*. This focused on transformation with regards to the social structure and organization of labour in eastern Germany. The second was written in 1895, and titled *Der Nationalstaat und die Volkswirtschaftspolitik*.

One of the main transformations observed by Weber concerned the increase of seasonal workers and the consequent decrease (relative or absolute) of the permanent labour-force in Germany at the end of the 1800. The seasonal workers, who ousted the permanent labour-force, were always migrants from Poland who were attracted by the work available in beetroot cultivation. This type of transformation brings about consequences on the social, cultural and political level, and Weber put forward important questions regarding the:

- Causes of immigration of Polish seasonal workers,
- Reasons of emigration or immigration under the Polish migrants' point of view,
- Political and economical intervention tending to solve the problems that the immigration created.

As far as the causes are concerned, the major one identified is the economic interests of the landowners who preferred employing seasonal workers from Poland because of their less sophisticated needs in comparison to those of German workers. Thus economic interests supported the immigration of Polish workers, but also opposed, on the other

hand, the national interest of German cultural prestige. What Weber referred to as a *Slavic invasion* could be seen as a cultural regression of the German *Volk*. As far as the reasons are concerned, Weber identified that lower salaries were paid to the Polish workers. On a psychological level, Weber stated that the emigrant would never accept the conditions experienced in his own nation, but does in the distant work place. With this secondary life-style, along with not having any 'home duties', the worker can save a great quantity of money, even if it is lower than the local salary.

Lastly, as far as economic and political intervention is concerned, Weber tended to consider such a problem as a "cultural question". The main thesis which the author put forward was that one nationality ousts another as a result of adaptation to particular conditions. Hence we can assume that the main focus of the Weberian approach is the social analysis of causes and effects of migration, and the dimension regarding the social and economical politics in this regard.

A sixth important approach I would like to discuss is the ecological-social approach outlined by Robert Ezra Park, who was a sociologist working within the Chicago School.

His was the first attempt to analyze patterns of immigrant/city interaction. Park assumed that in spite of the poor conditions in which newcomers find themselves in a different context, the final step will be assimilation into the host society. This involves a triadic process of contact/competition, conflict/accommodation and finally assimilation. This postulates the disappearance of ethnic differences, and involves a total "Americanization" of the newcomers. As Heisler points out, many scholars who have worked within Park's pattern have observed the relation between immigrant and host society as a unilinear movement only from the migrant's point of view, hence giving to the host society a sort of static characteristic as, mainly in Gordon's perspective, *the society remains virtually untouched and unchanged in this process* (1975 in Heisler 1992:84).

1.2. Structuralist Theories

Theories of the *modern period* (Heisler 1992), as outlined in the introduction of this chapter, have been developed by structuralist and neo-Marxist theorists. The change in

the pattern of studying migration during this period, which started in the 1960s, was mainly due to an historical change in the US society due to the Civil Rights movement, mainly driven by black Americans who were actually far from being assimilated, indeed their experience was rather of continued exclusion.

Structuralist perspectives started by assuming that international migration was a product of the capitalist system of inequity and domination: migration helps to maintain the capitalist system. This is done through the supply of cheap labour to capitalist and developed countries. The main model followed here is the model built by Wallerstein (1974), which describes world society as composed of core, semi-periphery and periphery sections. Generally Western societies were seen as the core, leading the developing countries in the periphery of the world. The world system perspective makes few distinctions between refugees and immigrants (Portes & Bach 1985 in Hein 1993). Migration from the core to the periphery, as occurred with European settler societies in North America (Bailyn 1986 in Hein 1993), and immigration within the core, as in Europe following both World Wars (Marrus 1985 in Heisler 1992), both reveal a mix of economic and political flows. Migration from the periphery to the core also includes both refugees and immigrants. Between 1975 and 1990, over 2.5 million refugees from Asia, Africa, and the Middle East gained residence in the First World (US Committee on Refugees 1992). France, Sweden, and Germany are the leading European host countries, and refugee arrivals began just after the ending of labor immigration in 1973-74. Refugees are part of continuing immigration flows in Australia, Canada, and the United States; Asia and Latin America have replaced Europe as the source of refugee admissions, paralleling changes in immigrant admissions. Most of the concepts elaborated on in the structuralist approach are summarized by *enclave-theories* (Heisler 1992:628), which focus on inequality and competition in the labour market. Heisler points out that “*labor markets are typically segmented or become segmented as a result of immigration*” (Heisler 1992:628).

As Heisler highlights, combining the world’s imperialism and the enclave models renders us better able to analyze the new global scenario. The first stresses the political dependence of ‘sending’ countries, and the second stresses the economic sphere, such as

labour market incorporation, since “*we cannot assume that labour market incorporation is epiphenomenal with social and political incorporation*” (Heisler 1992: 632).

1.3. *The Contemporary models: Multiculturalism and Citizenship*

The world system perspective cannot explain how the historical process of state formation and collapse creates refugees in particular countries (Zolberg 1981). The world population is increasingly divided into citizens protected by their state and people who are not members of a functioning nation-state. The Kurds of Iraq and the Muslims of Bosnia are among a growing population of displaced persons who remain within their home state but are either persecuted or not protected by it.

The increased salience of international institutions in protecting refugees is an indicator of the weakness of the nation-state system. UN refugee relief expenditures and the number of interventions in Asia and Africa rose dramatically beginning in the 1970s (Pitman 1987).

The concept of multiculturalism has become a core concept in contemporary social analysis, and particularly in migration theories. Steve Fenton (in Rex & Singh, 2004) argues that at the end of the twentieth century and at the beginning of the twenty-first century, the terms ethnicity and multiculturalism have been rehabilitated. Ethnicity has gained recognition as a concept which allows for the expression of new identities. There is also the idea that identities are neither fixed nor essential and that the carriers of a culture are representatives capable of reshaping their worlds. Thus “*new ethnicities*” (in Rex & Singh, 2004) can be represented as a continuing reproach to essentialized ideas of groups and cultures. Multiculturalism has received a new image partly because it has widened its scope from education to a definition suited to whole societies in a globalizing world, where sociology has become more aware of the importance of culture and its formulation.

Canada and Australia stand out among countries of immigration in making multiculturalism a specific policy goal. In both, the turn toward multiculturalism was a response to the perceived collapse of previous assimilation policy. In Europe, the idea of

multiculturalism did not originate with policy-makers, but with intellectuals and immigrant sympathizers associated with the political left. In South Africa such a concept is not used in policy making circles, *even though South Africa shares a sort of international Anglophone culture* (Bekker & Leilde 2004:157). As Bekker and Leilde (2004) point out, the expression often applied in South Africa to analyze the diversity in this country is *divided* (Bekker & Leilde 2004:157), a concept which underlines more than cultural diversity, suggesting concurring gaps along lines of inequity and hence high potential for violence and struggles within the society.

As far as these two perspectives are concerned, we can assume that the main focus is the political recognition of immigrants; as Heisler affirms, *society is perceived as a hierarchized set of systems of action and it is not founded on its economy or its idea, it is action and social relations* (Heisler, 1992: 635). In this view, migrants tend to create conflict in order to develop alternative institutions by organizing themselves into social movements; it is only through political struggles that migrants can set in motion the growth of a multicultural society.

According to Jones (in Mangalam & Schwarzeller 1968), studying migration means studying the involvement of socio-psychological processes, by *treating adjustment within the context of socialization, and studying the significance of new members to a social system with emphasis on the relation of the system's functional requirements to its methods of dealing with new members* (Jones, in Mangalam & Schwarzeller 1968:10). In a modern definition made by Max Weber, the notion of 'nation' was considered as *the agency within society, which holds the monopoly of violence* (in Pollini & Scida 2001). Since the development of the social contract theory, the modern state has gained full legitimacy only with those members of the fundamental contract – that being the citizens.

Thomas Fleiner (in Willigenburg, Heeger & Der Burg 1994: 196) argued that we must recall the global dimension of contemporary societies, and we should reject the "totalitarian" concept of the state which has to be limited to the political and civil society. It should be opened for all human beings, who should never have to be "hostages" of their own borders. Today there is no aspect of public life which is not interpretable in a perspective that goes beyond the borders of local societies, and/or nations. If it is only for

a decade that we have talked about globalization, it is because it has come into a new dimension: globalization is now the horizon of a political and social transformation aimed at a trans-nationalism of industries and markets and the progressive disappearance of local and national restrictions. This has the effect of exacerbating the life-conditions of a wider quota of persons in both the developed economies, and the under-developed countries.

The de-industrialization of developed economies is a result of the delocalization of industries. Under such circumstances, the structure of developed economies is modifying. The inequity does not coincide with the historical difference of classes due to a deep change in the labour structure. In a more globalized framework, the tendency to find a cheap labour force does not find any obstacle all over the world. The world economy is producing inequity with western companies going along with lower salaries and forced forms of labour. The will to escape local bonds such as poverty, slavery and oppression is the least we can expect from the millions of human beings who move away from their homes. Civil wars and famine provide a necessity to migrate. Migration represents a paradox in that the transfer of goods, symbols and human beings only goes one way, and is controlled by rich countries who want to serve their own interests, and the poor, in the periphery of the world, are restricted in accessing it, in other words, are excluded from the freedom of movement. Such a problem appears mostly when we talk about refugees, by generating the “democratic” illusion to manage migration and refugee flows. This involves plans of international cooperation: only by making them citizens we can keep them from being non-persons.

According to Jeremy Waldron (in Willigenburg, Heeger & Der Burg 1994), a cosmopolitan approach conveys a much more accurate sense of our involvement with “Others”. This is not only economically and politically based, but also culturally: Kymlicka’s (1989) perspective is very useful in understanding such an assertion. Kymlicka shows that people need cultural meanings, thus Kymlicka argues about the existence of different communities as a means to ensure the security of the cultural framework from which people make their choices and build their belonging and identity. Another viewpoint is provided by Coleman (1996 in Nyamnjoh 2006), in “Individualizing Justice through Multiculturalism: The Liberals’ Dilemma”. A premise

that underlies Coleman's article is that the culture of non-European immigrants is bound by anthropological constructions such as “rituals”, “customs”, “native practices” and “traditions”. The freezing of non-European culture in such forms as “custom” or “practice” emerges from colonialist and imperialist discourse which opposes tradition (East) and modernity (West), and which associates East with ancient ritual, despotism, and barbarity, and West with progress, democracy, and enlightenment. This assumption prohibits examination of the way that culture is differently experienced and contested within communities. Without such an understanding, representations of culture are limited to being defined by stereotypes. The term *Makwerekwere* with which local Black South-Africans name all foreign Black Africans is an index of how the tension, due to a heavy migration flow, is taking place in South Africa; and, according to Nyamnjoh (2006), the growing importance of identity politics and more exclusionary ideas of citizenship are matched by the urge to detect difference and to distinguish between locals or *insiders*, and foreigners or *outsiders*, with the focus on opportunities, cultural recognition and political representation. In this framework, Francesco Remotti (1996) subverts the concept of identity, often seen as something that has to deal with the term of structure rather than flow under an essentialist point of view, and underlines the mutable feature of such a term, writing that identity does not exist, but there are several ways to build it: Identity is always built and invented, depending on the mutation of social factors.

1.4. *The problem of identity and belonging in a multicultural context*

Theo van Willigenburg (1994) has written an article based on the concept of identity and belonging, where he assumed that people’s identities are constrained by the culture in which they are entrenched, so that *the self is encumbered and necessarily infected with its social cultural and historical context*. The sense of belonging leads to a constitution of communities in which the sense of self is constructed in a dialogical way as reaction to one’s relations with others (Taylor 1992 in Willigenburg 1994). The concept of identity that van Willigenburg proposes is constituted by a specific pattern of central features of ideas, behaviors, feelings and achievements; and such a centrality derives from a complex design in which subjective appropriation and social determination are involved dialogi-

cally, so that the term identity is not linked to the essence of an object, it rather depends on our decision and so we must focus on such a concept as something continuously built and re-invented (Remotti, 1996). In such a framework we can recall the image of Makwerekwere and the conceptualization of such a term as a new identity in which African migrants recall themselves, and are identified, in the South African context (Nyamnjoh, 2006). Tilly (in Brubaker & Cooper, 2000) summarizes the relationship between the social organization of migration and ethnicity as *networks migrate, categories stay put, and networks create new categories*. Yet categories also *create* migration because ethnic groups vary in the degree to which “migrant” becomes an identity.

From the realist perspective, exile is a definitive event for refugees and has important consequences for social identity (Rose 1993). After founding the state of Israel, Jews explicitly conceptualized their refugee policy as "in-gathering exiles" (Korazim 1988). Most Palestinians have not experienced forced migration, yet exile remains a communal experience (Abu-Lughod 1988). Tribal Afghanis have an indigenous conception of *asylum* seeker that combines elements of Islamic history with traditional migration to kin in time of war (Centlivres & Centlivres-Demont 1988; Edwards 1986).

For the Hmong of Laos, another stateless people, the term refugee has positive connotations (Hassoun & Mignot 1983). But for the Vietnamese, whose national identity is 2000 years old; refugee means separation from the homeland and has negative connotations. The ethnic Chinese of Cambodia and Vietnam, who have resisted assimilation for generations, prefer the term “overseas Chinese” to “refugee” because the latter implies rootlessness (Hassoun & Tan 1986).

Conditions in the host society also influence the process of identity formation. Cubans in Miami identify themselves as “refugee”, “ethnic minority” or “citizen” depending on the degree of nativism (Portes 1984) and the categories prioritized by the American political system (Maingot 1986). Direct state intervention can change refugees’ conceptions of the family and ethnicity (Goldstein 1986, Hein 1991a, Skinner & Hendricks 1979).

Refugees employed in resettlement agencies become brokers for refugees, or middlemen for their organizations, depending on their ethnicity, community politics, and the goals of social welfare policy on refugees (Gold 1992, Hein 1988, Indra 1987). In a multicultural

perspective, as Michael Sandel (in Avineri, De-Shalit, 1992) writes, “*we need communal belonging, because belonging confers character and depth on our choices and our actions, as the communities to which we belong communicate important and determinate conceptions of the good*” (and, I would add, the bad). Balibar (1995) argues about the existence of another characteristic of belonging that is “*the citizen as the subjectus still and always present, submitting to the inner voice of consciousness that informs him or her of his or her responsibility*” (Balibar 1995: 12). What Balibar asserts is the opposition between the host society and the different “trans-national” minorities, which are referred to as *insiders* and *outsiders*. Nyamnjoh (2006) considers immigration as a political issue and the growth of xenophobic, or ethnocentric, behaviors as a consequence; at this point I found useful a link to Babacan (2004) who sees Race and Racism as *value-laden notions that carry with them a set of assumptions about power relations in society* (2004:10).

Charles Tilly distinguishes identity as a *blurred but indispensable concept and defines it as an actor's experience of a category, tie, role, network, group or organization, coupled with a public representation of that experience; the public representation often takes the form of a shared story, a narrative* (in Rogers Brubaker and Frederick Cooper, 2000:12).

Charles Taylor (1989) and psychologist Roy Baumeister (1986) hint at a change in modern identity; moving from attributes that were basically determined at birth in medieval times, to identities that are much more subjected to choice in the modern era. Rogers Brubaker and Frederick Cooper (2000) point out the problem of reification as a social process, not only an intellectual practice; *as such, it is central to the politics of "ethnicity," "race," "nation," and other putative "identities". Analysts of this kind of politics should seek to account for this process of reification. We should seek to explain the processes and mechanisms through which what has been called the "political fiction" of the "nation" - or of the "ethnic group," "race," or other putative "identity" - can crystallize, at certain moments, as a powerful, compelling reality. But we should avoid unintentionally reproducing or reinforcing such reification by uncritically adopting categories of practice as categories of analysis* (Brubaker and Cooper, 2000: 5). In this context, the issue of identity as ‘politics of belonging’ forces us to confront the dynamics of identity-building, which appears to involve the inclusion and recognition of one, and the inevitable exclusion, lack of recognition, and explicit non-belonging of the other.

With this assumption, Dal Lago (2005) focuses on the migrant as a subject able to become a *non-person*, as a slave of his own nationality. We can assume that being a person or a non-person is due to the rules related to the concept of citizenship in conjunction with the concept of multiculturalism, which has wider implications for understanding social inequality and social integration. Citizenship becomes *the best general framework for analyzing the processes of immigrant/host society patterns of interaction* (Heisler 1992:638). Babacan (2004) talks about citizenship in a global era as *disengaging belonging from nationality* (2004:9); international migration poses many problem to the nation-state: migrants and refugees move with their cultures and histories, creating the main problem concerning their incorporation into other national cultures, thus resulting into their social exclusion. This is a cause of conflict for those not fully incorporated and thus it may provide a source for social movement organization.

Today only the citizens of those states which have a sophisticated juridical culture enjoy the right to be a person. The true western democracies have created a double regime for foreigners or for their own foreign citizens. An illegal migrant, or a refugee, does not exist in a social way, or, he/she exists but is encapsulated in a limbo from which he can be put aside at anytime. So we can say that illegal immigrants, in our society, are wrapped in a membrane of invisibility, a migrant is only a marginal human being. The Webster dictionary defines a non-person as *a person that usually for political or ideological reasons is removed from recognition or consideration* (in Dal Lago 2005:208). We can conclude that a non-person is considered in such a way as a result of cultural and social processes which modify the image of the “*man*” in itself. According to Marcel Mauss (1965) the Latin *persona*, originates from the ritual mask used during sacred dances, used to represent the clan or “*gens*”, combined with the *cognomen* with which people used to refer to any clan, giving to the term *persona* deep meanings of belonging and sense of inclusion within a family and within a whole community (Dal Lago 2005: 213-215). In *The Division of Labor*, Durkheim observed that the level of social differentiation of a population is a positive function of the level of rivalry for scarce resources among members of that population, with rivalry being a constructive and stabilizing function of the degree of natural concentration. The latter, as a function of the level of constrictive geographical limitations, demonstrates the scale of political

centralization and the degree of agreement over cultural symbols (c.f. Turner 1981:382-383).

Binnie Kristal Andersson (2000) wrote an interesting work on the psychological status of refugees. She argues that in clinical and support work, it became apparent that the social identity of the refugee and immigrant seems to influence their psychological difficulties. Several studies suggested that social identity can affect the individual's well-being. Cooley (in Andersson 2000) and Mead (in Andersson 2000) were among the first to recognize the self as a product of social interaction and that we see ourselves as others see us. Cooley used the terms "*self-concept*" and the "*looking-glass self*" to suggest the idea that self-concepts reveal the appraisals of other people in the environment. Jenkins (in Andersson 2000) presented sociological and social anthropological approaches to social identity and argued that this key concept should be seen as both individual and collective. The individual/family's social identities in the country of origin, and also in the new one, are taken into consideration within several aspects of the framework: the *states of being*; the *adaptation cycle*; *relevant background conditions*; the *reason*; and *transition-related conditions*. Several sociological studies appear to confirm the importance of considering and respecting the cultural and ethnic background of the individual/family in psychotherapeutic and support work.

Conclusions

At one time, the distinction between economic and political migrants was the primary conceptual basis for distinguishing types of international migration.

The world system theory provided the first social constructionist review of this realist perspective. As Hein pointed out, *the dichotomy is false, it suggested, because political conditions can cause the economic problems that lead to migration. In addition, more than 90% of contemporary refugees reside in peripheral countries in Africa, Asia, and Latin America. The potential for large numbers of refugees from new peripheral societies in the former Soviet Union substantiates the view that refugees are indicators of status in the world system* (Hein 1993:55).

A theory of global social conflict in the nation-state system supports a modified realist perspective. Refugee crises are a result of the political dynamics of state creation and transformation, and of increasing global interdependence, which erodes the stability of national states. Nonetheless, analysis of western refugee policy supports the nominalist perspective because who is or is not admitted as a refugee remains closely tied to foreign policy interests. The simultaneous rise of supranational state groupings and sub-national ethnic mobilization requires a rethinking of citizenship, sovereignty, and the nation-state.

Moving from global patterns in refugee flows and crises to the social organization of migration, a realist perspective from the push-pull theory distinguishes between planned migration by immigrants and spontaneous flight by refugees. In fact, both refugees and immigrants use social networks to make their passage from homeland to host society. But refugees resettled abroad generally cannot engage in circular migration, as immigrants can, although repatriation is increasingly the only option for many refugees.

Refugee migrations more often consist of families and associates sharing similar social characteristics as a result of departure conditions, while immigrant migrations involve the consecutive arrival of individuals and sub-household groupings. Refugees are more likely to view their condition as one of exile and to include migration in their social identity. The attitudinal and behavioral consequences of these distinctions remain to be explored. Yet a recurring finding is that political change and state intervention cause this variation in the organization of refugee and immigrant migrations (Hein 1993).

With respect to adaptation in a host society, the nominalist perspective is correct that “refugee” is often a residue of migration rather than a form of adjustment to a new environment. The same demographic variables predict employment status and earnings for immigrants and refugees. Both populations adapt as households and obtain income from multiple sources. However, state intervention once again produces some important differences, particularly of access to the social welfare system.

In relation to standards of protection it has been suggested that far from harmonization being the norm *asylum policy in Europe has become more disparate* (Joly 1999:347).

Throughout the 1990s there has been a general trend towards the reduction in use of Convention status and the substitution of a range of lesser statuses, such as *de facto* and hu-

manitarian status. According to Joly *Convention status is limited to a small percentage of asylum applicants, less than 10 per cent in 1996* (1999:347). In the absence of systematic data on this subject it is possible only to point to several illustrations. To take the case of the Somalis in the Netherlands and the UK (discussed in Böcker and Havinga 1998: 257), although the Netherlands was the principal destination country for Somalis in the EU until 1994, this situation was reversed in the latter half of the 1990s, with the majority of Somalis in the EU going to the UK.

Significant differences exist in the interpretation of the 1951 Geneva Convention between Member States relating to the issue of the origin of persecution. While in the case of persecution by state authorities all Member States may award refugee status, in the case of persecution by non-state agents there is a wide spectrum of policy and practice (EP 2000:11). An essential distinction in terms of policy impacts is the position, maintained in the EU by Germany and France, that the word persecution in Article IA of the Convention *includes only human rights abuses that originate with, or are encouraged or tolerated by, governments or 'state-like' authorities* (Edminster 2000:1). The increased saliency and use of temporary protection measures is commonly presented in the literature as one of the most significant developments of the 1990s, introduced principally by UNHCR and the EU as a 'reactive response' to the war in former Yugoslavia (Joly 1999:346; UNHCR 1997, 2000; Edminster 2000; Guild 1999). Again, although the introduction of temporary protection has been widespread, there has also been considerable variation in the type and implementation of temporary protection measures across EU Member States. As Schuster (2000) notes, Germany and Italy were amongst the first to grant temporary protection to refugees from the former Yugoslavia in the early 1990s, thereby taking them out of the normal asylum channels. This practice was quickly followed by other EU states and repeated under the Humanitarian Evacuation Programme (HEP) launched as a response to the flight of Kosovo Albanians in May and June 1999. While the direct impact of these measures is to "reduce the number of asylum seekers by removing large numbers of them from the asylum process" (Schuster 2000:124), variable indirect impacts follow from the different entitlements – in terms of family reunion, welfare benefits and length of residence permit for example – which temporary protection offers in relation to Convention and other statuses.

Italy, for example, confers the right to work for those with temporary protection (Vincenzi 2000). On the whole, fewer rights are attached to those with temporary status in comparison to those with Convention status. Joly (1999:346) cites the example of Denmark, where those granted temporary status in 1995 were kept in a camp where they were not taught the host country's language or encouraged to participate in the host society, and sadly such a pattern was adopted in Italy since 1998 with the introduction of the Centers for Temporary Residence, enclosed structures from which the so-called *Illegal* cannot go out, and in which they have to stay until their status is clarified, sometimes instead of the 60 days prescribed by the UNHCR, it takes even longer (Dal Lago 2005).

By focusing on the particular object of my study, I decided to use the access to Health Care facilities as an indicator of the extent of social exclusion for the refugee population, in order to understand if and how South Africa is producing inequity within a sub-system such as the Health Care sector. The rights of refugees and asylum seekers in South Africa are found in the Refugees Act and are derived from the international agreements that South Africa has signed, as well as the Bill of Rights (Chapter 2) of the Constitution of South Africa. Except for the right to vote, refugees and asylum seekers are afforded virtually the same rights as South African nationals including full legal protection of the Bill of Rights of the Constitution. Refugees and asylum seekers in South Africa also have the right to the same basic health services which South Africans are entitled to, at the same charge as South Africans.

In South Africa, refugees settle among the local population and are not provided any material assistance from the government. This means that access to basic services for refugees is provided in the same way as to South Africans. With only initial or emergency assistance available to refugees and asylum seekers is from NGO's, refugees are meant to be self-reliant and integrate into the community virtually unassisted.

It is the responsibility of the government of South Africa to assist refugees to better access the services that are provided (i.e. at the local government level) and to which they are entitled. This means that it is incumbent on government employees and front-line service providers i.e. police, school administrators and hospital workers to be familiar with the refugee legislation, refugees' needs and the rights that refugees are entitled to.

Refugees and asylum seekers also experience difficulties in access to health care and medical treatment for chronic diseases including HIV and AIDS in South Africa, particularly in the state hospitals. Access is often hindered owing to poverty, language barriers, and the failure of hospital staff to recognize the rights of refugees or asylum seekers.

The state hospitals require a fee and generally ask for national identification documents in order for individuals to receive medical attention and treatment. Clinics, on the other hand, provide free medical attention or primary health care. The hospitals instituted a fee because of resource pressures, in part caused by the large number of non-nationals seeking services there. However, the fee affects refugees and asylum seekers more than other immigrants, as they generally have fewer alternative options.

Several NGOs have engaged public health care officials to ensure that health care is accessible to all migrants, refugees and asylum seekers, at all state hospitals. Unfortunately until November 2007 the main problem in accessing Health care was encountered by those newcomers who only had an Appointment slip as document and, since such a paper does not give any details apart from fingerprints, the name and the surname, it was not possible to consider it as a legal document, so that many newcomers were rejected when trying to access public hospitals. In the following chapters I will explain such issues in detail by reporting what refugees reveal during the interview process, and the statistics related to the survey which I conducted with 729 refugees.

2. METHODOLOGY

As far as methodological issues are concerned, I at first decided to rely on a qualitative approach by collecting semi-structured in depth interviews (SSDIs) within ARESTA's¹ premises, but after a first attempt I faced the main problem of a serious linguistic barrier which led me to collect such interviews only within the Advanced Class of the English Project. The implications and severity of this problem led me to adopt a quantitative approach and use the data rising from the 15 SSDIs to construct the questionnaire to administer in the second stage of my research.

2.1 *Qualitative method*

When I started to design the research, the main goal was to focus on Health Care as an indicator of the way the local welfare system was coping with refugee issues. I initially thought that a qualitative approach would be the most effective for such a research topic, since my aim was, as Babbie and Mouton (2005) write, more focused on describing and understanding refugee issues on this particular topic rather than explaining human behaviour (Babbie & Mouton 2005:270)

Unfortunately, during the pilot stage of the research, I became acutely aware of the serious problem that the linguistic barrier between my intended respondents and I posed.

A great number of asylum seekers and refugees were not able to talk and understand English and I was not able to talk either French or Portuguese or Somali or Swahili which are the main spoken languages amongst them. Faced with this problem I thought I could use the qualitative interview data I did manage to obtain to inform and design a questionnaire to be used in a quantitative study.

The interviews I did manage to secure were treated as confidential and the agreement was that interviewees would remain anonymous.

¹Agency for Refugee Education, Skills Training and Advocacy, it is mainly focused on English courses for refugees and it has been running such a project since 1998.

2.1.1 *Sampling and strategies of the qualitative study*

I wanted to draw a sample that was as representative as possible, by relying on the UNHCR 2005 report² on the refugee population living in South Africa which stated that “Zimbabwe was the largest source of applicants (more than 8,000 cases), followed by Ethiopia and Somalia, and while the sharpest decrease in applicants was from the Democratic Republic of the Congo (DRC)” (in UNHCR Global Report 2005:258). Since I faced the problem to not being able to access any official data from Home Affairs regarding the refugee population in Cape Town, I decided, partly for reasons concerning the cost of undertaking such an approach, to rely on the refugee population which was referred to ARESTA and to interview 25 people. Since my task was an understanding of the refugees’ issues in accessing health care, I thought not to focus my attention only on nationality, but also on the type of permit held by the refugees attending ARESTA’s classes, so I started collecting information regarding such a variable, and in a second stage I worked out a sample which took into account also the English level of the respondents, and I stratified my sample proportionally to the size of each English class and to the gender.

Nonetheless I had to recognize a great difficulty due to a linguistic barrier from those refugees attending the beginner English level who had very poor English, so I decided to focus on those ones who were attending the Advanced Class, which unfortunately was composed of 15 students, 10 Males and 5 Females who, apart from one female student from Rwanda and one female student from Somalia, were coming from the Democratic Republic of Congo and so, it was impossible to select people with different social and historical backgrounds from which I could actually draw a representative sample of the refugee population within the Cape Town area.

2.1.2 *Field experience*

In March 2007 I went to the class and I explained to the refugees that ARESTA was conducting research on refugees and Public Health in the Cape Town Area, and that this

²After consulting the Cape Town Refugee Office at the Home Affairs I have found out that they did not have any official statistics on the refugee population based in the Cape Town Area.

research was going to focus on Human Rights issues in terms of access and equity in the Health Care system and the kind of problems refugees were experiencing in accessing healthcares. When the refugees came to the office I explained in detail the research purpose but at first they did not understand it very well. By relying on Miles and Huberman's (1994) approach which merges the use of interview questions and themes rising from data to enlighten analysis, I decided to start with a broad question related to their general life in South Africa to determine what problems were creating difficulties in accessing healthcares, and using open questions to let my respondents be confident with the topic I was investigating before narrowing my questions strictly on the point of my dissertation topic. I explained to the refugees that I was not interested in a list of the physical problems they have but rather in knowing their personal experiences with hospitals and doctors, and their feelings relating to them and I underlined that the all interviewees' names would remain anonymous.

At first refugees asked me if ARESTA was going to give them money to go to hospital, and in response to my negative answer, some of them asked me why I was going to ask them for an interview, so I explained to them that no money was promised and that this work was research with the intention to understand the refugees' point of view regarding the rights and wrongs in the Health Care system. I decided to hold the interview in the office at ARESTA after the class, as before, the office was quite busy with refugees coming and going, asking various questions and because I had noticed that refugees do not really like interrupting the lesson in the middle. As far as probable linguistic problems were concerned, I bore in mind that English is not their first language, and, by remembering my own experience (as an Italian speaker with some command of English) when I came to South Africa, I tried to maintain my questions at a very simple linguistic level, by using examples; but I noticed that the strategy to refer to practical examples gave the appearance that the respondents were getting influenced by them and were not sharing with me their experiences, and I had the impression that they were trying to agree with my examples instead of, maybe, denying what I was saying. I can say that the only question the refugees did not understand was one referring to a language problem, so I had to opt for a practical example like: *When the doctor was explaining your situation,*

were you able to understand everything? Instead of using a question like: Did you encounter any linguistic problem in referring to the hospital staff?

By agreeing with Williams (1978) and Baumann (1992) that one of the aims of qualitative research is to discover the range of behaviours and attitudes upon a topic, and that the essence of qualitative research is an unstructured and flexible approach of interviewing that allows the widest possible exploration of views and behaviour patterns able to provide important insight into the complexity and range of human attitudes, I decided, while planning these interviews, to start using a very broad topic guide, asking few questions while encouraging my respondents to talk as freely as they could.

I decided to focus my research purpose as *“how identity politics and politics of belonging are affecting and shaping refugees’ lives in the South African scenario?”* Under such a research purpose, and by using the Health Care system as an indicator of the extent of the welfare system in the Country, I came up with the central research question which is: *“How fair is the access of Refugees to basic needs in the South African multicultural scenario?”*

By re-reading the material which I was collecting, I realised that I was not able to highlight meanings which could be generalised, not only for problems regarding the language, but also for the limitation due to a too homogeneous a sample which included only refugees coming from DRC (Democratic Republic of Congo).

2.1.3 From qualitative to quantitative study

By noticing the problem regarding language and the homogeneous nature of the sample, I attempted to ask the students to write a composition of 7 to 10 pages by using the SSDI questions letting the respondents write it in French and in Portuguese, in order to be able to involve the refugees of the other classes and maybe being able to have a representative sample; but on twelve people who decided to write this small essay, only four of them came back to me, and three of them just limited to answer Yes or No to the questions.

Noticing all these obstacles, I finally decided to use this qualitative material to inform and design the questionnaire to use in the second stage of my research and use quotes from such interviews to integrate with the survey results.

2.2 Quantitative approach

2.2.1 Sampling and selection issues

Once I had collected the SSDI's, I thought I had enough material to design the questionnaire for the second part of my study. The quantitative approach was decided, as I have already written above, to overcome all the problems and enquires rising from the obstacles encountered in conducting a qualitative study, such as linguistic problems which affected the possibility to build a sample and the possibility to collect different points of view from respondents coming from different cultural backgrounds.

At first, I had to face the issue of building a sample to use for my purpose of study.

The first step was to contact all the organizations working within the Tutumike Network³ in order to announce my research and to obtain permission to use their databases to have a picture of the refugee population. I actually relied on them because I faced the problem within the Refugee Office at Home Affairs which told me clearly that they did not have a database showing the refugee population in the Cape Town Area.

After a number of meetings with all the NGO's I collected their databases in order to build a sample frame. The only NGO which decided not to share their data was the Cape Town Refugee Centre which put forward issues related to the privacy of their clients as I explained that the database should include the refugees' contact details and they did not want to break their confidentiality. The databases which I could access were those of ARESTA (Agency for Refugee Education, Skills Training and Advocacy), Scalabrini Refugee Centre and PPASA (Planned Parenthood Association of South Africa), which were the main NGO's dealing with Refugees' health care. By bearing in mind what Moser and Kalton (1971) wrote about non-response, and by thinking that within the

³ The Tutumike Network involves 10 NGO's countrywide dealing with refugees' issues.

refugee population I could come across a large number of people who might have changed their telephone number or their address, I asked the above-mentioned NGO's to give me access to their 2006 list in order to limit, as much as I could, the bias that these types of non-response could bring.

The first step was to merge and clean the databases in order to have a consolidated database without repetition of persons. Unfortunately many of the records did not have any contact detail (telephone number and/or physical address), so I had to delete them from the final list. This database constituted the sample frame of the study. The sampling method used in my study was *systematic sampling* with the use of *stratification* techniques. According to Moser and Kalton (1971), systematic sampling produces better representation in the sample selected from a population list than does simple random sampling. As we know, one of the aims of the sampling is the precision that it must achieve. Stratifying does not mean any different approach from the principle of randomness. All it means is that, before any selection takes place, the population is divided into a number of strata; then a random sample is selected within each stratum. As far as my study is concerned I first select a number of persons within each stratum which in this case was represented from the nationalities and then I selected proportionally men and women per each stratum and in the appendix we can see the table referring to this calculation. In my case I have decided to stratify my sample first per nationality and then per gender proportional to each country of origin, but for ethical and privacy reasons I have decided not to show the personal details of the final sample.

As far as the sample size is concerned, the required sample size depends on two factors: the degree of accuracy and the extent to which there is variation in the population in consideration to the main characteristic of the study, so we need first of all to decide how much error we are prepared to accept (De Vaus, 1975). Having estimated the sample size, it may turn out that it represents a sizeable proportion of the population, so that the finite population correction ought to be included. Apart from requiring that we can specify the degree of precision needed, we must also have a rough idea of the split; the other problem is that often we wish to analyze subgroups separately, and this brings us to a final issue that we should think ahead to how we intend to analyze the results, so a key determinant of sample size is the need to look separately at different subgroups.

Moreover De Vaus (2005) closes by saying that desired accuracy is not the only factor in working out the sample size, but also cost and time are key factors and the final sample size will be a compromise between cost, accuracy and ensuring sufficient numbers for meaningful subgroup analysis, underlining the importance of doing stratification. As far as my study is concerned, I firstly decided to set a probability level at 95% and a confidence interval at 5% in order to have high accuracy, but the sample size which came out was too large in terms of cost of conducting such a survey, as the final size was 1523. So after a consultation with Prof. Owen Crankshaw of the Department of Sociology at the University of Cape Town, I decided to set the confidence interval at 10%, and I arrived at a sample size of 381. Since I postulated that the refugees' choice of medical assistance could be influenced by their religious confession, and being Muslim areas underestimated in my sample frame I decided to rely on a non-PPS sampling (probability not proportional to the size) with regard to nationality in order to insure sufficient numbers of cases from each for analysis, thus I used the sample size I obtained previously and I selected 381 respondents from what I called Christian countries (Table 1.2 in APPENDIX) and 381 respondents from the Muslim countries (Table 1.3 in APPENDIX). As far as the gender is concerned, I rely on a PPS sampling design (probability proportional to the size) and selected males and females proportionally to each stratum (Tables 1.2-1.3).

2.2.2 Questionnaire design and field experience

By re-reading the in-depth interviews, I decided to use them in designing my questionnaire for the survey, as the essence of this work is to be able to build a structure to apply to the questionnaire.

Once collected all these data, experiences and question marks, deriving from my interviews, I began to formulate hypotheses using all the common elements I have found, to understand which pieces of my information were to be considered as independent and dependent variables (Marsh 1979). In my study I decided to treat the variables Country of Origin, Gender, Religion and Age as independent variables and the others as dependent in

order to understand how language skills, education, occupation, medical choices and social networking of the respondents vary in relation to the former variables.

The questionnaire based interviews were conducted in English, French and Portuguese by an interview team of ARESTA which was the Organization that has given me support in running the survey. This team included four people, two of them had a sociological background and interview and research experience while we trained the other two by explaining the research design and purpose as well as the questionnaire to them in detail, and instructed them about how to approach the respondents. During the interview process I decided to assist the latter in administering the questionnaires as there were some questions which required, depending on the respondent's answer, the skipping of entire parts of the questionnaire, such as for those respondents who did not have any medical history: all those questions referring to it had to be skipped and treated as not applicable.

The interview process was run in July-August 2007 as a telephone and face-to-face (PAPI) based survey.

During the interview process I came across the problem of non-response, either because the respondents had moved from the place they registered in the database, or they had changed their telephone number or (the greater number) because they simply refused to answer for personal reasons. These problems, as I affirmed above, were limited by the fact that I referred to the 2006 lists which I supposed to be more reliable. With the ARESTA team we decided to run the interviews during working hours (9am to 16.30pm) and we divided the list into three sections, the first included those nationalities who were more likely to speak French and Swahili, the second included those who were coming from either English speaking countries or Somalia and we had to suppose they could speak English, as we could not find anyone who was likely to be their interpreter and able to talk Somali; the last sections included those who were from Angola and Mozambique with Portuguese mother tongue. If respondents did not answer the phone I asked my colleagues to tick their names on the list and try every half-hour in order to reach them.

In the end, the non-response rate was only 5% and I arrived at the end of August with 729 completed questionnaires out of 762. According to the literature (Kish 1965; Moser & Kalton 1971), significant biasing effects from non-responses usually result when the non-

response proportion (R_2) is higher than 20%. As for the non-response types I encountered 15 were persons who refused to answer and 18 were persons who had changed their address or contact number.

2.2.3 Coding

As far as the methodological aspects are concerned, I was guided by De Vaus' (2005) point of view explained in *Analysing Social Science Data* and *Surveys in Social Research*.

Coding, as de Vaus (2005) writes, is a method of representing categories and values of a variable so that responses are converted to a form appropriate for statistical analysis and data become more controllable by grouping similar responses.

In appendix (1) I have included a copy of the questionnaire I used in my dissertation. Mostly I have designed dichotomous questions as we can see the questions no 6, 9, 19, 32, 35, 41, 44, 45, 47, 49, 61, 71, and 72. Another type of question I used was open-ended question as far as the answer "other" and the question 3, 8, 31, 33, 34, 38, 40, 60, 70 are concerned and I decided to post-code them once I collected the questionnaires.

Once I collected the questionnaires, I started the process of building a data matrix and I used the software SPSS. Once I completed the entries of my data I relied on two methods to check for errors: valid range check and filer check, the former is obtained by calculating the frequencies of each variable to see if erroneous code-numbers were shown up, and the latter is obtained by crossing any question with those questions which relate to them to check if any wrong answer was showing (i.e. the case of respondents who affirmed to not have ever gone to any health care facility who maybe answered other related questions which had to be treated as not applicable).

Once I completed these operations, I started cleaning the data matrix and I had to prepare my variables for analysis. By relying on de Vaus (2005) I used the technique of collapsing categories, which means accommodating the many categories that a variable can have in order to have better readable tables. In my study I have used this approach for the variables Education, Age and Income, Work Categories and Years of Stay in South

Africa by rearranging the first in four categories from the 15 which I had previously, and as for the others I clustered the variable age in 6 groups, the variable income in 9 groups, the variable work categories in 5 groups on the base of the 2006 South African Labour force Survey, and the variable years of stay in 3 groups.

Finally, once I prepared the data matrix I started the process of data analysis by relying on univariate statistics as for the demographic profile is concerned and on bivariate analysis as for the relation with the Health Care system is concerned and the results of such analysis will be shown in Chapter 5.

University of Cape Town

3. ISSUES SURROUNDING MIGRATION AND REFUGEES IN SOUTH AFRICA

The Bill of Rights, which is part of the South African Constitution, recognizes the international law which refers to freedom of movement, particularly in section 21.

The implication of this is that SA accepts the right of people to move from SA to other countries and for people to move to SA from other countries for reasons such as temporary visits, migration and asylum. The position of refugees requires special attention: On September 1993, a basic agreement between the Government of the Republic of South Africa and the United Nation High Commissioner for Refugees (UNHCR) was concluded. The agreement set out the policy regarding persons seeking asylum in South Africa. In 1996 South Africa acceded to the 1951 Geneva Convention Relating to the Status of Refugees and the 1967 Protocol (New York) to the Convention. South Africa also became, in 1996, a member of the Organization of African Unity (OAU) and of the Convention Governing the Specific Aspects of Refugee Protection of 10 September 1969. Until recently, applications for asylum and refugee status were dealt with in terms of the Alien Control Act 96 of 1991. The Refugee Act 130/1998 now provides a new refugee regime which aims to reflect the principles contained in various international instruments dealing with refugees. The Refugees Act is a vast improvement over previous legislation in South Africa. It formally recognizes refugees and asylum seekers as a group entitled to international protection. The Refugees Act outlines the rights and obligations of refugees and asylum seekers and creates relevant institutional bodies such as the Standing Committee for Refugee Affairs and the Refugee Appeals Board, as well as formalizing procedures for refugee status determination, documentation, appeals, and judicial review.

However, in practice there are significant disparities between the law as it is outlined in the Refugees Act and its regulations (as well as in the South African constitution and the various international refugee and human rights conventions to which South Africa is a party), and its implementation.

According to Jonathan Mafukidze (2006:116-133), migration flows include labour migration and involuntary migration flows represented by human trafficking, IDP's (internal displaced people), refugees and child migration.

In the African context, the major change has been the emergence of the South as a migration destination for other African countries in the past fifteen years, and migrants are encountering high levels of xenophobia either at a public opinion level, or at an institutionalized level, and according to Loren Landau (2004), we can talk about South Africa as a country of *inhospitality* (2004: 2-3) as far as the migration laws are concerned.

Although the movement of the greater number of migrants across Africa is related to economic interest, quite a big percentage of those who moved from around the Great Lakes region and West Africa did so due to political causes and created large refugee populations in the various part of Africa, South Africa included.

By focusing on the situation of refugees, we can say that both the Great Lakes region and the Horn of Africa region have undergone a traumatic political evolution that includes military regimes which were responsible for civil wars of unprecedented proportion, forcing a huge mass of refugees and IDP's to move, implementing forced and involuntary migrations.

The Southern Africa Migration Project (Crush & Pendleton 2006: 11-16) identifies several migration streams, including:

- Growth in the volume and complexity of cross border movements,
- Restructuring of traditional contract labour systems,
- Declining levels of legal migration within the region,
- Expansion of undocumented migration and trafficking,
- Increase of skills brain drain from the region,
- Resettlement and reintegration of mass refugee movements,

- Feminization of cross-border migration
- Growth in intra-regional informal cross-border trade,
- Rapid urbanization.

Related to the main migration streams, the current number of legal migrants reaches over 5 million people, adding a new form of racism, as migrants are viewed as carriers of disease, takers of job and perpetrators of crime, and in this context, policy has tended to focus on control and exclusion.

Political debates and policy challenges associated with immigration are leading to a reconsideration of national identities within national, social, economic, and political communities throughout the world. Focusing on these debates' public facets reveals much about the quality of a country's democracy, but may ignore an additional set of informal reactions and quotidian practices that marginalize immigrants and other vulnerable groups such as refugees. Beyond the 5 million legal migrants, South Africa is facing the issue of undocumented migration of now around 8-10 million people (UNHCR 2005). Within this messy framework of more than 10 million foreigners in the country, the new democracy is facing the arrival of a huge mass of refugees. In the 1990s, there has been a new and stable southward flow of forced migrants and South Africa now hosts considerable Francophone African and Nigerian urban communities and, according to the South African Migration Project (SAMP 2004), between 1994 and 2001, 64000 applications were made for refugee status inside the country. With resources becoming more limited and migration flows rising, migration xenophobia is increasing in many parts of Africa (Mafukidze 2006, Landau 2004), including some areas where regional migration has had a long history and which were formerly fairly tolerant. Africa's rising xenophobia is often matched by increasing xenophobia overseas, especially in recent destinations where migration from Africa is not traditional practice. In South Africa, *migrants have often been objects of violence and victimization, and xenophobic feeling with disregard of migrants' rights has risen sharply in Botswana* (HUMAN RIGHTS WATCH, 2005: 10-63). The refugee crisis, concentrated in Central and West Africa, is at

an unprecedented level which international agencies struggle to cope with. This is complicated by almost equal numbers of internally displaced persons, who fall outside the United Nations net and do not receive systematic aid (HUMAN RIGHTS WATCH, 2005).

South African civil society long debated legislation that became the Refugees Act No. 130 of 1998 (Refugees Act), which did not come into force until its regulations were published in April 2000. The Refugees Act and its regulations define the legal standard for refugee status, establish South Africa's asylum procedure, and set out the rights and obligations of refugees and asylum seekers. In spite of a comprehensive law, however, many refugees and asylum seekers continue to face significant obstacles to their right to seek and enjoy effective protection in South Africa.

In 1999, before the Refugees Act came into force, 54,759 asylum applications had been lodged. Out of this number, 8,504 were recognized as refugees, 25,020 were rejected, and 21,295 applications were pending (UNHCR 2000). By the end of 2004, the provisional number of asylum applications pending according to the UNHCR (UNHCR, 2005) had risen to 115,224 of which 32,600 were new applications. In addition, the Department of Home Affairs granted refugee status to 27,683 asylum seekers largely from the Democratic Republic of Congo, Somalia, Angola and Rwanda. This brought the total of the asylum seeker and refugee population to 142,907 by the end of 2004. The asylum application accumulation makes up a large proportion of this group.

The excess of asylum applications has largely been a result of poor planning and inadequate preparation for the implementation of the Refugees Act. The government did not adequately manage the transfer of asylum applicants issued under the Aliens Control Act to the new system. Too few immigration officials were hired and trained to administer the Refugees Act. DHA and UNHCR implemented a Backlog Project to reduce the number of pending asylum applications issued under the Aliens Control Act between 2000 and 2001.

As noted in the UNHCR Global Report (2005), corruption in the refugee reception office and the failure by officials to restrict the activities of "brokers" and unofficial

“*interpreters*” further hinder the ability of asylum seekers to gain access to refugee status determination procedures and protection.

Even the in-depth interviews have revealed problems and slow service and corruption in obtaining the permit. For example, respondents commented as follows:

“I’m Congolese, from DRC, and I arrived in Jo’burg in December 2006 and by February 2007 I moved to Cape Town and when I arrived I first went to the Home Affairs and they gave me an Appointment to October 2007 and I think this is very far”. (*DRC Asylum Seeker, Male*).

“I’m from DRC, and when I came here, I came nine months ago, and I was sick, and the first problem when you come at the Home Affairs you take a long time to do your things, one week and maybe two weeks and You have the papers, I mean the Appointment, we come at FIVE o’clock and we found the extension, You go up and down for more than one week” (*DRC Asylum Seeker, Female*)

“I had to wait one and a half week to get the small paper, the small Appointment, then they gave us a three months Appointment for the permit Interview but it was the period, it was the end of 2005 and the Home Affairs was full of people [.....] personally the problem I faced at Home Affairs was the huge number of people and I think that such a big number of people stuck the bureaucratic work of the people who are working there, and maybe the Refugee Office requires more staff” (*Rwandan Refugee, Female*)

“My problem is the problem that the whole Somali community is facing, people demand money from us, maybe 1000Rands, maybe 1500 Rands for issuing the paper, they give the Appointment for three or six months but at the same time if you communicate to someone of the Agency which have relationship with someone in the Office they also charge you 2000 Rands and You can see that they assist you the same day with no problem, there is a lot of corruption there at the Home Affairs, [.....] one day I took one of my cousins, she was eight months pregnant, and I took her because she needed to go to Hospital, but with only the Appointment no Hospital was taking care of her, but it was Saturday and they normally don’t work there and they didn’t help her, so I said “Why people if they pay money You always give them the help they need?”, ja, because like fifty people they give like 800 Rands each, but we didn’t have the money and they get angry and officer, I don’t remember the name now, but I said to him: “Can You please show me the person and how much we must give?” and he asked me to follow him then we went down the stairs

and we met the officer George and he said “ Hey ****¹ what you are doing it’s not nice”, so I asked: “Why, what am I doing?” so, my sister she come from Johannesburg and now she is here for three weeks now and nobody is helping her but if people have money you help them, Why? And now it’s already twelve o’clock and by two without money we didn’t even get the Appointment so he left us downstairs so I said “OK this is how it works”, so after that they gave us an Appointment for September and this is the way other Somali are dealing with our problems, always it comes to money, but even if I tried to stop the corruption this is still on, I know the name, and they are able to corrupt local people, and people like my sister who don’t have the money they gave her a hard time because she didn’t have the money.....”(Somali Refugee, Female)

After an asylum seeker has gained access to the refugee reception office and been issued with an asylum seeker permit, procedural delays continue. UNHCR, supported by the UN General Assembly, has consistently noted the need for asylum procedures to be “*efficient, expeditious and fair*” (UNHCR 2005). As part of the Global Consultations on International Protection, UNHCR sought to identify the key elements central to all asylum seekers, recognizing the inherent differences in states’ capacities and resources. The key elements identified by UNHCR included “*staying in dignity, freedom of movement, respect for family life, access to education, access to health, information on procedure and rights in their chosen language*” (UNHCR 2005).

South Africa’s domestic refugee law also recognizes the need for refugee status determination procedures to occur with relative speed; as noted above, the regulations to the Refugees Act envision status determinations to be finalized within six months (180 days) of the submission of an asylum application. A survey commissioned by UNHCR in 2003, for example, found that 70 percent of respondents (in this case, all of whom were asylum seekers) had not had their claims adjudicated within 180 days of submitting their asylum applications.

Outside of the refugee status determination process, asylum seekers and refugees are often subjected to harassment, mistreatment and extortion by police. Numerous news reports (Cape Argus 08/2005, Special Assignment SABC3 Sept. 2006) have highlighted

¹The name of the interviewee has been treated as confidential and thus obscured to respect the respondent’s privacy.

that a dark skin complexion or not sounding “South African” are common reasons why police may question and detain certain people.

Even refugees and asylum seekers with valid documentation are not protected from harassment and extortion by law enforcement officials. Judgment of the immigration status of any person in South Africa is made, in most cases, by police officers, who are rarely trained in the specifics of refugee and asylum law or procedures, are unwilling or unable to accept the validity of the array of official identity documents, and often must deal with asylum seekers and refugees who are evasive about their identity or legal status for fear of being deported to a place where they may face persecution or civil conflict.

As the interviews have revealed, there seems to be a general feeling of frustration among Refugees and NGO’s:

“Refugees are not animals or one class of abandoned people” (*DRC Refugee Male*)

“It is important for us to continuously be doing legal actions, and unfortunately you’ll see that xenophobic comments and feelings brought out from officials and when we see officials making these comments it is OUR duty to go and trying to educate them because they have to approach us in a very dignified and human way, so there is a problem, but even local people are treated like that often” (*Miriam Friedrich, Trauma Center*)

“The lady who was taking the interview was very rude at first, she was asking me: “So are you in political troubles? So why are you only talking about political problems? Are you a politician?” I said: “Nooo!” in a very angry way: “I’m a future lawyer, I can’t explain properly because I don’t know how to speak English!” I didn’t even know if the translator was speaking in a good English and she was saying: “I can’t believe You”, but she was not in Congo, she doesn’t know nothing about Congo, and I started to discuss with her, she really made me angry. I said to myself, oh my God, why does she want to know all these things from me, why is she complicating everything? She was a coloured lady, ja a coloured. And after she said : “If we should find out it is not true, You gonna go back”, and I said : “ No problem anytime, anytime, anytime”, she was trying to intimidate me, but I like stay in South Africa, but not like that, I’m always alone, sometimes with some stress, I feel stressed, I want to go home now...” (*DRC Asylum Seeker Male*)

Beyond the problems associated with access to refugee status determination procedures and the inadequate protection which such individuals often receive, refugees and asylum seekers in South Africa also have difficulties gaining access to work, primary education, basic health care services, public relief and assistance, education beyond the primary levels, housing, and permission to practice their professions.

The ability of refugees and asylum seekers to secure such social and economic basic needs is particularly complex in countries like South Africa which faces challenges in providing these necessities to their own nationals (Loren Landau 2004). The insecure legal status of asylum seekers (and occasionally, due to administrative failures, of refugees), the lack of recognition of refugee and asylum seeker's documentation by those in charge of granting access to benefits and needs place this group in an especially vulnerable position (Dal Lago 2005).

Refugees and asylum seekers also experience difficulties in accessing health care, particularly in the state hospitals, as it is often hindered owing to poverty, language barriers, and the failure of hospital staff to recognize refugee or asylum seeker documentation (UCT Medical School Survey 2005).

As I wrote at the end of the previous chapter, state hospitals require a fee and generally ask for national identification documents in order to receive medical attention and treatment. Clinics, on the other hand, provide free medical attention or primary health care, but the real problems, as it clearly emerges from the following answers, concerns linguistic barriers and those who do not have either the asylum seeker permit (S.22) or the Refugee Status (S.24), as the Appointment slip is not legally recognized;

“.....it is first of all a matter of money, because we haven't got good jobs here and I think that the jobs that we have got here are only for 1500R, we have to pay the house because we are renting house and You can find Refugees in one room and maybe we are like five or six persons or even eleven persons in one room because they have to partake, I don't know, this one must give I don't know, 100R, that one 200R so that they can organize to pay the rent of that house, but as the houses are very expensive, and the major problem we have here is the problem of houses and all the money that we can gain, we pay for the house, so by the end we don't have nothing left for going to the doctor and pay for the cares” (*DRC Asylum Seeker, Male*).

“.....they only said “She doesn’t have money, I can’t do nothing for this girl”, the only one possibility is to take off the womb, but now I know this can’t help me because I’m sick, but now, if I have a job, but now I don’t have a job, they can’t give me the tablets the only chance is to take off my womb²” (*DRC Refugee, Female*).

“Actually I would need to see a doctor but I prefer not to go to Hospital because what my friends said about Hospitals in South Africa, long queues and rude staff, so when I’m feeling sick I prefer to take some Panado or something like that; and with so little money how can You think we can afford if we are sick, we can only take Panado, my friend went to Hospital, and they only gave him Panado and they treat him so bad, they were shouting at him because he couldn’t understand anything, that’s the reason why I don’t go, because if you want good care you need to go to a Private Hospital, but you need money, and the little money we have, we must save for rent and food so we can’t, and also in the Public Hospital they don’t receive us they leave us standing in the queue and they tell us to come back. I can’t stand that, I already had enough at the Home Affairs. You see, there is nothing for free, I must pay the rent, I must pay money, so I don’t have money to pay Health cares, or to pay for studying, [.....].for Refugees it takes so long, You must wake up at four or five in the morning, stand in the queue, You wait for many people standing in the queue waiting for treatments, so why must I go there for nothing, it just waste my time. There are so many Refugees from Congo, from Rwanda, Ethiopia, Somalia, I know the story about Refugees, they are only taken as Refugees, so I know that wherever We go people look at Us as Refugees, as Makwerekwere, we are in South Africa just to work, and only because our Countries are in war or whatever, I hate when they ask me why are You in South Africa, You must go back to Your Country I feel so stressed, I don’t want someone to talk to me like that: “Hay suga wena, Makwerekwere!”, and they go on talking about me in Xhosa or in Afrikaans, I don’t know what they say but I know they are talking to me, I don’t like that, also in the Hospital they talk their language they don’t like us, so I don’t like going there, really, I don’t.” (*DRC Refugee, Male*)

“...the Medical English is very hard, so many of the people when they go to the Hospital the doctor can tell them to do this and that, maybe laying on the bed, do You understand what I mean?, Medical English is very hard and most of the foreigner people they don’t speak English, you know what I mean?, they can even give the wrong problem, maybe the doctor can say “ So where is the pain?” You can say “maybe my lungs or maybe stomach but if You don’t know you can give the wrong information about it and from there the doctor can treat You badly not because he’s wrong, but it can confuse them, that’s why foreign people they need someone maybe in the clinic to help them to understand and being understood, ja, maybe they can even teach them Medical English” (*Rwandan Refugee, Female*).

²In this interviews the respondent was referring to a disease of her womb and for money problems the only way to be cured was to intervene surgically on the womb itself, something that would have made her lose her fertility

“...by that time I had problem, but the doctor tried to explain me for me to understand, because he understand that I was difficult in English, and me also I tried to understand my doctor, it was very difficult, but me I do the sign to explain him what I had, but I think this is a problem, because I was lucky to find him, but other friends told me that it is not like that in other Hospitals, a lot of doctors treat us as stupid, and don't give help, and a lot of Refugees can't understand the English. We know what happens in our body but a lot of times we don't know how to explain. No one talk French or Portuguese, so it is really difficult and there is no one to translate” (*DRC Asylum Seeker, Female*).

Several NGOs which are part of the Tutumike Network, have engaged public health care officials to ensure that health care is accessible to all migrants, refugees and asylum seekers at all state hospitals.

One of these NGOs is ADRO (African Disabled Refugee Organization), a non-Profit Organization registered in terms of the N.P.O Act. The Organization aims to promote the interests of Disabled Refugees who are victims of ethnic-political conflicts, racism and xenophobia. ADRO's objectives are to develop education and skills training programs for its members as well as to create a conducive environment where all Disabled Refugees can be assisted in dignity irrespective of race, gender, ability, age, tribe, or nationality. Some refugees, however become disabled after they arrive here. Usually this is due to attacks perpetrated by South African criminals who perceive foreigners to be easy targets. Services are not adequate and access to these facilities is disabled unfriendly. In the Department of Home Affairs they can only assist a limited number per day and the able refugees are in a better position to reach and access these resources. Disabled refugees also encounter problems with finding suitable jobs³.

Another organization is CTTC (Cape Town Refugee Centre) funded by UNHCR and the Department of Social Services. It includes ten volunteers, two social workers and one social counselor, as well as officers. Some of the staff can speak French and can help when a visitor cannot make him/herself understood. Among the many projects which the CTTC is running, the more interesting for my study is the Self Reliance Programme, like the Life Skills Program in conjunction with the PPASA (Planned Parenthood Association

³The information derives from an interview with the Manager of ADRO (Anaclet), and the interview was held by Audrey de Luzanne, intern at ARESTA

of South Africa) which provides a sexual and reproductive health education workshop and financial contribution to health cares, as refugees have to pay a minimum amount of R35 in public clinics/hospitals. CTRC can help and pay for it in certain cases thanks to UNHCR funds. Besides, some Health services such as mother and child care are completely free⁴.

The third organization which I met is the Trauma Centre in District Six which works with psycho-social services in terms of psychotherapeutic counseling for those refugees victim of torture, and they also run Stress Management courses for this particular kind of refugee and debriefing because sometimes their stories report strong traumatization⁵

The Scalabrini Refugee Service has a project which assists Refugees with disabilities, people with chronic diseases, terminal diseases and people who are involved in accidents.

In these cases a refugee contacts them and they send him/her to a hospital making sure that they will follow the process. The ones who have problems with English are provided with a translator, but the main problem is with the documentation: The hospitals cannot assist those ones who do not have the right documents, such as the people with only an appointment as the doctors and the staff are not likely to assist them for the reasons I explained above regarding the legal cost of such appointments⁶.

The Refugee Project at PPASA (Planned Parenthood Association of South Africa) started only in 2000 and it aims to increase knowledge and information of Sexual and Reproductive Health and to increase access to proper Health Care for the refugees who are living in South Africa. Because of cultural and language barrier the Refugee Project provides Health information to the refugee community by running different activities such as workshops with Refugee Centers like ARESTA, Cape Town Refugee Centre, Bonne Esperance, Home Affairs and Scalabrini Refugee Service to empower refugees in sexual and reproductive Health issues. They also provide condoms in the Cape Metropol, and they assist refugees in the Hospitals with translators for those who do not understand

⁴ The information regarding the CTRC comes from an interview held by Audrey de Luzanne with Christina Henda, Manager of the organization

⁵ The information regarding the Trauma Centre was obtained through an interview process with Miriam Friedrichs

⁶ The information about the Scalabrini Refugee Service was obtained through an interview with Dixon Sylvanus

English, but as for the latter they have only six people because of a lack of funds. Another important activity is the HIV/AIDS support for Refugees who are infected or affected by HIV/AIDS, a support tout court, with an HIV Counsellor who provides psychological and legal help.

The NGO's speak of a problem with refugee documents, and often, as shown below, there is great frustration with those who own only an Appointment slip. This derives from a lack of understanding and acceptance from the Health Care Providers of the permits that the Refugees hold, as well as a lack of communication between the Department of Home Affairs and the Department of Health.

“the Appointment doesn't say a lot, just your name and the finger prints and these things, with the big delay in processing their request, is making the refugees frustrated, because it is making it difficult to access not only to health care, but to any other issue in the country, we work very close with the Department of Home Affairs, I mean the Refugee Office, and for me it's not a problem whenever I call there is always someone I trust, and on the other side the Social Service they always assist us when some of them have problems, and I can add they we really have a good relation with the Department of Home Affairs, so it's easy for Scalabrini get that documentation so that they can go for their treatments, but we did encounter, I remember, one problem with a child who was a Refugee around eighteen years old and he didn't have any documentation, but he needed to go to hospital because he was affected from a particular syndrome, but he was really sick but without any document, they had to send him home until he renewed his papers, and he was very weak, and he was very frustrated, can you imagine going to hospital because you are very sick but they can't assist you just because you don't have a full documentation, and he had to go back home and wait for us to go and renew his documents, and after going back to the hospital and then they could assist him, these are some of the issues we can encounter, and so I can say more that racism, the documentation is the main problem which can actually affect their lives in doing their medical things” (*Dixon Sylvanus, Scalabrini Refugee Service*).

“...this is a problem of Education, it should be a duty of the DHA [*Department of Home Affairs*] and the Department of Health to know that these people are entitled to receive basic health cares, but it is also our duty, duty of the Tutumike network to scream that Refugees have the right to education, the right to work, the right to be assisted in health care, except the right to vote, they have the same rights of all South African and a lot of people, especially doctors and staff nurses are totally unaware of that” (*Miriam Friedrick, Trauma Center Management*)

“In some Hospitals, they may not pay attention to the Refugees because of the papers, they say “Can I have Your ID or Your Passport?”, so when they find out that they only have that paper, they assume that they are illegal immigrant or illegal Refugees and they will say this person doesn’t have ID to be received in the Hospital because they don’t have a proper paper. The Hospitals need also Your identification for them to get a record, to keep records and so on, so once they don’t understand the Refugee papers are issued by the section 22, or 24 at the Department of Home Affairs, that become difficult, maybe they will send Refugee to go and find illegal papers and that is a problem and sometimes Home Affairs delays on issuing the papers to the Refugees, You see someone in Cape Town for six months or more but he doesn’t have any paper besides an appointment and if the same person is sick and goes to Hospital it should be difficult for him to be received because he doesn’t have a legal document showing that this person is legal, because the Appointment doesn’t have an address, and, Ja, that is REALLY the main challenge” (*Freddy Nkosi, Refugee Project, PPASA*).

Rodolf Lekogo (in Cross, 2006) analyses the reasons why migrants choose South Africa, underlining that this country is the strongest and the most diversified economy on the African continent, and that its health infrastructure is comparable to the European ones. The government’s obligations under international refugee and human rights law and the South African constitution, founded on the principles of non-discrimination and dignity, place a duty on the state to create an enabling environment that allows all persons, including refugees and asylum seekers, to have access to services. The state has a duty to protect these rights which include providing special assistance at the refugee reception offices and access to services such as education and suitable accommodation. UNHCR, which is charged under its mandate with protecting refugees and asylum seekers, should increase its assistance to the South African government to better coordinate policy and administration throughout its various government agencies, and so to facilitate access to services and assistance for refugees and asylum seekers without discrimination.

The following section will examine the role of NGO’s in assisting with Health Care issues, as well as discuss a common misunderstanding of the Health Care system by the Refugees themselves.

“.....when Refugees come, I explain to them the difference between a primary health care and a secondary health care system and they have first to go to a primary health care centre and they won't be seen immediately and they have to wait for an appointment but a lot of them don't understand that, and I find a big anger among Refugees when they go to the hospital and at first they are not seen and they often come back to me and I have to say “I told You that you won't be seen immediately” so I see that there is a misinterpretation, or misunderstanding,....” (*Miriam Friedrick, Trauma Center Management*)

“...there are different tools, there are different documents on Refugees Health rights and it is written and it should be known by everyone in the Hospital but it's not always the case because in the Hospital a lot of people are coming in and others are coming out concerning the medical staff but PPASA is running also a workshop in Hospitals within the medical staff that workshop is called “The Refugees' Health Rights” and we work with Doctors, Sisters, Nurses just to explain to them who are Refugees why they are coming to South Africa what are the challenges they are facing and their problems and so on and what are their Rights to access to proper Health Care like everyone because in South Africa the Constitution is written and known that everyone is, has rights to access to a proper Health Care or whatever, so we still running workshops in different Hospitals and Clinics...” (*Freddy Nkosi, Refugee Project PPASA*).

“At the Scalabrini we have a project which assists Refugees with disabilities, people with chronically disease, terminal diseases and people who are involved in accidents.

In these cases when the person, for example has an accident, he contacts us and we send him to a hospital and we make sure that they will follow the process, the ones who have problems with English we provide them a translator to talk for them, but the problem we are facing is as for the documentation and the problem with documentation is the most important one, the hospitals can't assist those ones who don't have right documents, and I am talking about the people with only an appointment and the doctors and the staff are not likely to assist them and the next problem is the transportation, because if a person stays let's say in Muizenberg, we only, I mean we have to pick him up, we are only able to pick no more than three people, and the ones who are very close and go to hospital, but it is going to be very early in the morning to avoid a big queue and usually they have to stand in the queue like all the South Africans” (*Dixon Sylvanus, Scalabrini Refugee Center*).

Besides the real existence of projects, which the NGO's are carrying on in favour of the Refugee community, the in-depth interviews have revealed a lack of trust towards the Organizations which work with Refugees, probably due to a lack of reliability and a lack of communication between NGO's and the Refugees Community.

“I don’t think that they can help me with money, because after the workshop they ask us to work with them as volunteers, but we can’t accept, we must struggle to have money and live here and I can’t go where they don’t give us money; I also went to the Cape Town Refugee Centre in Wynberg, they receive us, but they ask us many questions about our lives and the situations that we are passing through in this country, and after explaining our situation to them we thought that we could have help, but all we received was only 150R, but they ask questions and we are explaining them the problems of house, food, cares and children, and after all that explanation they only give us that three months voucher of 150R, what can we do with that 150R? You can only buy some food with that paper, I don’t know Shoprite voucher or whatever, and we can spend that piece of paper only in Shoprite only for food, and after one day You finish that money, You can’t go for that money, so it means that we can’t hope (?) to the organization without a real help” (*DRC Refugee Male*).

“Only the CTRC, they helped for three months but after they couldn’t, because they told me to help me for three months just the time to find a job, but to find a good job I need to study, they told me to bring the formulations and they could help me, but now I’m studying here at ARESTA and I’ll start maybe at a nursing school, I hope, they told me, in Wynberg not to worry, I hope” (*DRC Refugee Female*).

“...they don’t help Refugees on Health care issues, I’ve never seen them helping Refugees with Hospital, there’s the money for the projects, but there is nothing, but anyway what can we do? It’s fine, maybe we should improve the role of the Organizations, because only thanks to local friends I could go to Hospital, because the NGO don’t have contact at all and they don’t even tell You where to go..., ja...” (*Somali Refugee Female*)

In the in-depth interviews I have conducted, I asked them for suggestions to improve the Refugees’ situation within the South African context, and below I have reported the more interesting answers:

“...if there is a chance to talk with the UNHCR, the Minister of Health or the coordinator of NGO’s, ja, they should provide like translators in the hospitals or maybe the Minister can help foreigners who are studying or have studied as a doctor or a nurse in their own countries to be accessible to the hospital, to have a proper job...when I met my doctor there was no problem he never asked where I was coming from, no he just treat me as a local, because I can talk English, they just have to provide translators and everything will be ok” (*Rwandan Refugee, Female*).

“...in first place I would like to suggest to her to fundraise to get translators in all the Hospitals, clinics, government Hospitals or whatever; second to give education to the staff about Refugees’ issues, the next thing is there are times in which Refugees, I can say, once a child passed away at the Hospital after all the care, and the father was charged 16000R, OK the debt was out, but in cases like that when he had the documents which say he’s a Refugee and he’s not working they can’t just give a bill to him without saying anything and make him stressed, frustrated without knowing what to domaybe the Department of Health should set up a program with the Department of Home Affairs and the Refugee Reception Office that the Appointments need, like if they give one year appointment, they should need to be recognized, as besides the name there is a thumb print which can be used as ID proof, at least this can allow to let them access to basic treatments and so on, also because if you take a look at the UNHCR website how many request are still pending or in process, imagine if You have one year of waiting list and you need to visit a doctor and you get rejected just because of a paper, that’s why we would like to push in order to let these organizations accept the Appointment (*slip*), it can also be an emergency and You risk to die because their bureaucracy does not accept the Appointments, and if the emergency is in the night and they can’t come to Scalabrini because we are closed, they risk to die like this, accidents can happen anytime, so they must set up a program for this issue, at least they can be able to get the treatment like all human beings as they are entitled as according to the Refugee Act” (*Dixon Sylvanus, Scalabrini Refugee Service*).

“...language is the problem, so I think they should improve the language. So I think to improve the Refugees’ life they should give work, because care is expensive and without a proper job we can only pay rent and some food, but if we are really sick, we need to pay for our cures, also because there are many Refugees here and they are maybe doctors, engineers, like me, I’m a sister in the Congo, but no chance to work.....” (*DRC Refugee Female*)

“She [*the Minister of Health*] promised the Refugees to have that ID, the red one which includes Refugees like local people but a lot of them complain that they don’t have the Right the same Right of local people because with this ID they are supposed to get the grants people are sick and they need cure for their children they don’t get any disability grant when they go with the Refugees’ ID they get refused on these grants because they are not South African and even if the doctor give a letter and they go there they say no, You are not a South African and so they want money, ja, so we want the same rights that South African have, that we and our children, especially the ones with disabilities, can receive these grants, because cares are expensive.....” (*Somali Refugee, Female*).

“..I can suggest organizing one clinic where the refugees can have all the cares possible to be treated as people...” (*DRC Refugee, Male*).

Conclusions

What is analyzed in the present chapter reveals several problems which involve the government (DHA and Department of Health) and its relation to the public in terms of clarity as regards the procedures and institutional streams to follow, and a lack of clarity from the NGO's point of view in clarifying the Refugees' issues. The final chapter, which will provide a deep interpretation of the quantitative data, will reveal the same problems; nevertheless, we can see that the road towards a fair integration of the Refugee population is still a long way off. The country lacks real comprehension about the Refugees' needs in terms of assistance and basic services and corruption and slowness within Home Affairs is affecting the Refugees in terms of access to housings, documents and basic health care services. Furthermore, the lack of knowledge from the health care providers results in a poor impression about the effectiveness of the Health care system, the problem about the issuing of the permits results also in difficulties in accessing the labour market. As we will see in the final chapter the Refugee population has a generally higher education in comparison to local people, but the South African system struggles with the recognition of their certificates and, as will be examined later, it results in a sort of segregation of the whole community in an unskilled labour market.

4. ANALYSING THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

4.1. *The Health System and its Laws*

The following chapter will examine the Health sector by starting with the explanation of the terms access and equity, stated in the Charter of the Public and Private Health Sector of the Republic of South Africa, as:

- **Access**: capacity and means to obtain and use an affordable package of health care services in South Africa in a manner that is equitable;
- **Equity**: the fair and rational distribution of an affordable package of quality health care services to the entire population of South Africa, irrespective of patients' ability to pay for such services and irrespective of their race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language or birth.

In the above mentioned terms we can see that theoretically the Health sector should be reliable for everyone who lives in the Republic, but a significant number of people in South Africa do not have adequate access to health services due to geographical, financial, physical, communication, and sociological barriers such as unfair discrimination and stigmatization. As far as the above-mentioned Charter is concerned, the general challenges involve overcoming such barriers, by making available information relating to health and health services to all patients and addressing the particular needs of vulnerable groups. What would also improve the situation would be to investigate the creation of a category of independent practitioners contracted by the state to improve access to health care at the primary level. These practitioners would not refuse anyone emergency medical treatment, irrespective of whether or not they are able to pay. Equity involves ensuring equal access to equal care for equal need in a situation in which resources are efficiently utilized in a fair manner. The challenge is to develop a minimum defined basic package of health services without detracting from the principle of buy-ups

and other mechanisms of funding levels of care that are higher than the basic minimum. The basic package of care must reflect the minimum acceptable standard of health services to be made available as the health care safety net for all. Health outcomes and life expectancy for the poor and medium income groups are generally worse than those for high-income groups due to inequity in health services. The services to which the minority has access are far superior in terms of quality and quantity, to those to which the majority has access. The general challenges with regard to equity in health services are the lack of availability of a minimum defined basic package of health services to which everyone can have access irrespective of their ability to pay.

There is great stigmatization of persons on the basis of health conditions, reproductive decisions or treatment choices. This unfair discrimination (on the basis of sex, sexual orientation, gender, disability, health status, race, culture, religious beliefs and other grounds), must be eliminated from within health establishments, health professions, health services and the broader communities they serve. Unfair discrimination consists of acts or omissions, policies, laws, rules, practices, conditions or situations which directly or indirectly impose burdens, obligations or disadvantage on, or withhold benefits, opportunities or advantages from persons on one or more legally prohibited ground. To overcome such a problem, the government should develop a minimum defined basic package of care that is available to all patients in both the public and the private sectors regardless of the ability to pay. It should also eliminate inefficiencies from health service delivery as well as implement a policy of zero tolerance for unfair discrimination by health care personnel which will be communicated to all health care personnel employed by them together with the nature of the disciplinary steps that will be taken.

In 2004 the Department of Health published the Strategic Priorities for the National Health System (2004-2009) whose main mission is to improve health status through prevention and promotion of healthy lifestyles and to improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.

Beyond the goal to improve access and equity, nothing is said about an improvement of the situation of migrants, most of whom live in poor condition. The main points on which the plan is focused are the reorganization of support services, legislative reform, the

improvement of quality of care, the revitalization of public hospitals, and the decrease of mortality rates through strategic intervention.

Only within the above-mentioned charter, (Strategic Priorities for the National Health System) the goal to eliminate unfair discrimination on the basis of sex, sexual orientation, gender, disability, health status, race, culture, religious beliefs and other prohibited grounds is mentioned, but never in terms of migrant people.

Health services in South Africa make use of “the Road to Health Card” to ensure that children are immunised. Children not born in South Africa will not have these cards unless they are provided to mothers. The same lack of identification is underlined by the National Health Act 2004, whereas in the Chapter 1, within the vulnerable groups only women, children, older persons and persons with disabilities are mentioned, but there is not a specific reference to migrants and refugees.

4.2. Refugees' health needs

The main finding of a survey conducted by students of the 4th year at the UCT Medical School (Chiranjan, Egan, Gibson, Samsodien, 2005), in the Western Cape was that there is a large refugee population, with its own unique health needs and problems. Unfortunately, for a variety of reasons, refugees often find it difficult to access the health care to which they are constitutionally entitled.

Refugees often arrive with very little and struggle to gain access to basic necessities such as food and shelter.

The health needs of refugee women are many and have been poorly addressed. Many women are in need of reproductive health care and advice, access to family planning (contraception, choice on child spacing and family size), protection against sexual and gender-based violence and treatment of sexually transmitted infections including HIV/AIDS.

In South Africa there are many barriers to accessing the health care system which affect more than just refugees. These include not being able to exercise choice of the health care professional from whom treatment is obtained, difficulty in accessing the correct level of

care, large numbers of patients and consequent long waiting times, poor transport, lack of financial resources and an extremely expensive private sector. However, there are issues that relate more specifically to refugees, such as language barriers, xenophobia, lack of recognition of documents or lack of knowledge surrounding the structure of the health care system.

Refugees often arrive in their host country with few financial resources and, at least initially, find it difficult to obtain work. According to one report, lack of finances can be a major obstacle to accessing health care. Refugees in South Africa have great difficulty accessing work, and cannot afford to pay for transport or the fee requested at clinics or hospitals. Accessing private doctors is, understandably, also difficult, because of costs.

By taking a step back, we can find a sort of contradiction in the introduction of the Refugee Act (1998) as, it has been stated, among the different kind of rights, that:

A refugee is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time.

Besides the Refugee Act, the South African Constitution, in section 27, provides for the right to have access to health care, food, water and social security, and in according with this section, this right cannot be infringed by retrogressive measures, while reasonable legislative and implementation measures to achieve progressive realization of the right are required. The same section refers also to the concept of social assistance, underlining the right of access to it only if they are unable to support themselves.

As the South African Migration Project (SAMP) points out (Inter Press Service, 2005-02-10, in SAMP 2005), every year, thousands of Africans fleeing war and economic adversity make a dangerous flight towards South Africa. Along with hope for the future, many also bring with them the AIDS virus “*Refugees are regarded with suspicion in South Africa and are as a result discriminated against and barely integrated into society, let alone HIV and AIDS initiatives*” (Melita Sunjie, 2005, in SAMP 2005). These words are echoed by Nathan Geffen, spokesperson for the Treatment Action Campaign (TAC) - a leading anti-AIDS group in South Africa: *there are still high levels of xenophobia in*

South Africa, and because illegal immigrants and refugees lack power their interests are not represented (in SAMP 2005). According to the Department of Home Affairs, about 100,000 people have refugee status in South Africa. Most refugees originate in the Democratic Republic of Congo, Burundi, Rwanda, Angola, Somalia and - increasingly - Zimbabwe, where political and economic turmoil has prompted many to cross the border into South Africa. The HIV prevalence rates in these countries vary from 5.1% in Rwanda to 24.6% in Zimbabwe. South Africa's infection rate is put at 28%. Once given asylum status, refugees in South Africa have the right to seek treatment from the country's healthcare system in the event of illness, (illegal migrants have no such rights). Those granted asylum are also issued with identification cards to be shown at the hospitals where they go for care. In practice, however, having a card can mean little. *When a refugee comes to the hospital they have to present their documentation to prove their refugee status, but the staff at the registration point don't recognize the legitimacy of their identification cards because they haven't been properly educated* (Dr Bernard Uzabakirilo, in SAMP 2005). As a result patients are registered as illegal immigrants who have to pay a consultation fee (between R290 and R2,450) upfront before receiving treatment. Language barriers sometimes cause treatment to be delayed - if not denied. "When refugees phone or come to the hospital and can't speak English they are made to sit down and wait for a translator. I have seen patients who are made to wait for eight hours," (Uzabakirilo, 2005, in SAMP 2005). Repeated efforts by IPS to get comment from the Department of Health about the difficulties experienced by refugees at state hospitals were unsuccessful. Making matters still worse is the fact that the state machinery for processing asylum requests is painfully inefficient. Staff shortages and incompetence at the Department of Home Affairs have resulted in a backlog of over 50,000 applications for refugee status. *Because of the backlog, this process (of application) takes up to five years* (Carnita Ernest, in SAMP 2005).

A 2003 study conducted by the Community Agency for Social Enquiry (CASE), the most recent analysis of refugees and asylum seekers in South Africa, noted that of the 1,500 migrants interviewed, only 11% had been issued identification cards by Home Affairs. The remaining 89% had been waiting for over three years for asylum status. According to CASE's National Refugee Baseline Survey, about 20% who had tried to access

emergency healthcare were refused help, mainly by hospital administrative staff. CASE is a non-governmental organization based in Johannesburg. As the Refugees Act of 1998 places restrictions on asylum seekers by prohibiting their employment while their applications are being processed, HIV-positive migrants find themselves in limbo: unable to use state health facilities - or work to earn the money that may cover the costs of private health care.

These growing HIV/AIDS statistics can be attributed in part to other humanitarian issues which South Africa faces (SAMP 2004: 1-3), and these include: insufficient health care, lack of education and poverty. Poor living conditions are endured by a large percentage of South Africans who are forced to reside in informal, unsanitary settlements. South Africa struggles with xenophobia, which negatively affects migrant workers and refugees, and contributes to a very high crime rate. Xenophobia, in addition to widespread corruption of the police and a growing antagonism towards Robert Mugabe and his land reform, put Zimbabwean asylum seekers at particular risk of being deported. The economic crisis in Zimbabwe has resulted in an increase in the number of economic migrants fleeing to South Africa in search of work, thus provoking hostility on behalf of unemployed South Africans.

“The co-existence of high levels of both HIV/AIDS and migration in Southern Africa is not entirely surprising” (SAMP 2004: 5); not only does human mobility play a very significant role in the pandemic’s spread, but migration has been shown to make people particularly vulnerable to HIV infection. A third aspect of the relationship between HIV/AIDS and migration has thus far received much less attention, particularly in Southern Africa: namely, migration that takes place as a result of the pandemic.

AIDS imposes heavy costs at a number of levels, not only for those directly infected, but also for their families and wider communities. Coping strategies must be employed, and these sometimes involve the relocation of households or of individual household members.

5. FINDINGS

5.1 Demographic profile

This section aims to provide a detailed demographic description of the refugees in this survey in terms of the following variables: sex, age, marital status, fluency in English, education, occupation, types of employment and income.

| GENDER | | |
|---------------|------------|------------|
| | N | % |
| Male | 607 | 83 |
| Female | 122 | 17 |
| Total | 729 | 100 |

Table 5.1: Frequency and percentage distribution of respondents in terms of Gender

I obtained a sample where approximately eight out of ten interviews were conducted with men a result which echoes the UNHCR survey conducted in 2002.

5.2 The Refugee Status

Amongst the respondents, seven out of ten owned a valid permit, 54% of the respondents were Asylum seekers (S.22), and only 46% of them were granted with Refugee Status (S.24), this data is significant in terms of what I showed in Chapter 3 regarding the bureaucratic problems and the delays which the refugees encounter in accessing the necessary documents to be granted with the Refugee Status.

| OWN PERMIT | | |
|-------------------|------------|------------|
| | N | % |
| Yes | 508 | 70 |
| No | 221 | 30 |
| Total | 729 | 100 |

Table 5.2: Do you own any permit?

| WHICH PERMIT | N | % |
|--------------|------------|------------|
| | S22 | 272 |
| S24 | 236 | 46 |
| Total | 508 | 100 |

Table 5.3: What is your current status?

| COUNTRY | Type of Permit | | Total | N |
|--------------|----------------|-----------|------------|------------|
| | S22 | S24 | | |
| Angola | 69 | 31 | 100 | 51 |
| Burundi | 69 | 31 | 100 | 13 |
| DRC | 65 | 35 | 100 | 156 |
| Rwanda | 68 | 32 | 100 | 19 |
| Somalia | 100 | 0 | 100 | 7 |
| Tanzania | 37 | 63 | 100 | 216 |
| Other | 61 | 39 | 100 | 46 |
| Total | 54 | 46 | 100 | 508 |

Table 5.4: Current status by country of origin

If we look at the table above we can see that respondents from Tanzania have a higher rate of refugee status (63%), as opposed to most of the other countries where most of the respondents are Asylum seekers, nonetheless I did not find any particular evidence of this in previous researches, so this led me to assume that this data is linked to the length of staying in the Country, and in the next table we can see that the above mentioned community is in South Africa mainly for more than one year; 42% between one and three years, and 12% for a period between three and six years.

| COUNTRY | Years of staying | | | | Total | N |
|--------------|------------------|------------|------------|-----------|------------|------------|
| | %< than 1 year | %1-3 years | %4-6 years | %>7 years | | |
| Angola | 50 | 22 | 21 | 7 | 100 | 68 |
| Burundi | 96 | 4 | 0 | 0 | 100 | 24 |
| DRC | 59 | 29 | 9 | 3 | 100 | 231 |
| Rwanda | 77 | 23 | 0 | 0 | 100 | 22 |
| Somalia | 94 | 6 | 0 | 0 | 100 | 16 |
| Tanzania | 47 | 42 | 12 | 0 | 100 | 301 |
| Other | 69 | 19 | 7 | 4 | 100 | 67 |
| Total | 57 | 31 | 10 | 2 | 100 | 729 |

Table 5.5: Length of staying by Country of Origin

5.3 Age

The average age of respondents is 29 as we can see from the table below, and the youngest person interviewed was 15 and the oldest 47.

| COUNTRY | Age | Age | Age |
|--------------|-----------|-----------|-----------|
| | Mean | Minimum | Maximum |
| Angola | 30 | 15 | 43 |
| Burundi | 28 | 17 | 45 |
| DRC | 29 | 15 | 47 |
| Rwanda | 27 | 19 | 38 |
| Somalia | 25 | 18 | 41 |
| Tanzania | 30 | 17 | 47 |
| Other | 28 | 20 | 43 |
| Total | 29 | 15 | 47 |

| Eta | Value |
|---------|-------|
| COUNTRY | 0.13 |
| Age | 0.13 |

Table 5.6: Age of applicants by country of origin

Applicants from Burundi, Rwanda and Somalia seem to be slightly younger than other respondents from the other countries, but, as we can also see from the test reported above, the extent of the relation does not seem strong as the eta-value shows a strength of 0.13, which means that their correlation is only the 13%.

| AGE | GENDER | | Total |
|----------------|------------|------------|------------|
| | % Male | % Female | |
| 15-20 | 6 | 7 | 6 |
| 21-25 | 29 | 27 | 29 |
| 26-30 | 20 | 30 | 21 |
| 31-35 | 30 | 24 | 29 |
| 36-40 | 12 | 7 | 11 |
| 40 + | 4 | 5 | 4 |
| Total % | 100 | 100 | 100 |
| N | 607 | 122 | 729 |

| Age Groups | | | | |
|--------------|-------------------|----------|----------------|------------|
| GENDER | Mean ¹ | Median | Grouped Median | N |
| Male | 3 | 3 | 3 | 607 |
| Female | 3 | 3 | 3 | 122 |
| Total | 3 | 3 | 3 | 729 |

Table 5.7: Age by sex of respondents

By looking at the tables above we can see, in the first, that men and women tend to be older than 25 years and even though the difference is very small we can say that in average the Refugee/Asylum seekers population is relatively young and it falls mainly, as we can see from the test reported below, in the range between 26 and 30 years. In the literature (Ritchey, 1976) I have found that this is quite a diffuse pattern as the age is a typical push factor which plays a great role; in his study he wrote how the strength of migration decreases as age increases; this pattern is easily explained as individuals who are young are entering the labor force and their high rates of migration reflect the process of job search and experimentation in the early working years. Middle-age workers are more established in the labor force and experience less unemployment than the young, but move in response to career opportunities (Lansing & Mueller, in Ritchey 1976). Older workers are established in the labor force. However, they are less likely to migrate for economic reasons than their younger counterparts, because their remaining years in the labor force are limited and thus their employability is relatively lower.

¹ The value 3 of the mean and the median refers to the Age Group no 3 (26-30 years)

5.4 Marital Status

| MARITAL STATUS | | |
|-----------------------|------------|------------|
| | N | % |
| SINGLE | 358 | 49 |
| MARRIED | 340 | 47 |
| WIDOW | 15 | 2 |
| DIVORCED | 16 | 2 |
| Total | 729 | 100 |

Table 5.8: Current marital status

In my findings the percentage of singles and married has got very little variation, as we can see from the above-table, the percentage of single is almost the 50% against a 47% of married, almost non-existent is the percentage of widows and divorced which is only 2% of the interviewed population.

| MARITAL STATUS | GENDER | | Total |
|-----------------------|---------------|-----------------|--------------|
| | % Male | % Female | |
| SINGLE | 51 | 38 | 49 |
| MARRIED | 44 | 59 | 47 |
| WIDOW | 2 | 2 | 2 |
| DIVORCED | 2 | 2 | 2 |
| Total % | 100 | 100 | 100 |
| N | 607 | 122 | 729 |

| | Value | Approx. Sig. |
|-------------------|-------------|--------------|
| Phi | 0.11 | 0.03 |
| Cramer's V | 0.11 | 0.03 |

Table 5.9: Current marital status by sex

Males are more likely to be single (51%), while, in contrast, females are more likely to be married (59%), while the percentage of widows and divorced is exactly the same (2%). A larger family through marriage, childbearing, and the aging of children increases one's ties to the community. Therefore, each of these factors is an impediment to migration (Ritchey 1976).

| COUNTRY | MARITAL STATUS | | | | Total | N |
|--------------|----------------|-----------|----------|-----------|------------|------------|
| | %SINGLE | %MARRIED | %WIDOW | %DIVORCED | | |
| Angola | 35 | 65 | 0 | 0 | 100 | 68 |
| Burundi | 54 | 46 | 0 | 0 | 100 | 24 |
| DRC | 55 | 41 | 2 | 2 | 100 | 231 |
| Rwanda | 55 | 45 | 0 | 0 | 100 | 22 |
| Somalia | 69 | 31 | 0 | 0 | 100 | 16 |
| Tanzania | 44 | 50 | 3 | 4 | 100 | 301 |
| Other | 58 | 40 | 1 | 0 | 100 | 67 |
| Total | 49 | 47 | 2 | 2 | 100 | 729 |

Table 5.10: Current marital status by country of origin

Even though the data reveal that on average half of the applicants were single, in the above table we can see that, by country of origin, Angolans and Tanzanians are the most likely to be married with respect to the respondents from other countries, but I did not find in the literature anything to validate such a data; so I can assume that it is something related to the particular kind of sample I obtained as I had to rely on NGO's list and not on regional and official data.

5.5 Fluency in English

Assuming the importance of English in South Africa to be able to work or study, I asked my interviewees, the ones coming from non English speaking countries, whether they were fluent in English.

| COUNTRY | ENGLISH LEVEL | | | Total | N |
|--------------|---------------|-----------|------------|------------|------------|
| | %Poor | %Good | %Excellent | | |
| Angola | 56 | 37 | 7 | 100 | 68 |
| Burundi | 63 | 38 | 0 | 100 | 24 |
| DRC | 63 | 35 | 2 | 100 | 231 |
| Rwanda | 50 | 32 | 18 | 100 | 22 |
| Somalia | 44 | 25 | 31 | 100 | 16 |
| Other | 61 | 33 | 6 | 100 | 18 |
| Total | 60 | 35 | 5 | 100 | 379 |

| | |
|-------------------|-------------|
| Phi | 0.31 |
| Cramer's V | 0.22 |

Table 5.11: Fluency in English by country of origin

As we can see from the table 5.11, 60% admitted to have a poor level of English, and such data will be useful in the core discussion of my dissertation as the linguistic barrier will be discussed as the main reason for discouragement in accessing Health Care Institutions. Even though we look at the table country by country, we can see that such a proportion does not change, remaining substantially unchanged apart from the Somalis who seem to have better English for 31% of the cases. By looking at the summary statistics, we can say that there is a low relation as we look at the Cramer's V^2 (22%), so we can say that there is a low correlation between the two variables, which means that the level of English does not depend on the particular Country of Origin, that is the level of English is poor for everyone who does not come from English speaking countries.

| | GENDER | | |
|--------------|------------|------------|------------|
| | %Male | %Female | Total |
| Poor | 57 | 68 | 60 |
| Good | 37 | 29 | 35 |
| Excellent | 6 | 3 | 5 |
| Total | 100 | 100 | 100 |
| N | 275 | 104 | 379 |

| | Value |
|-------------------|-------------|
| Phi | 0.11 |
| Cramer's V | 0.11 |

Table 5.12: Fluency in English by sex of respondents

Males tend to be more likely than females to be fluent in English as we can see from the table above were 43% of male respondents revealed to have an English level either good or excellent against only 32% of female respondents, but the tests reported do not show a particular strong correlation between gender and English level, being the Cramer's V only on a value of 11%.

² The correlation coefficient X^2 (De Vaus 2005) is simply an index that provides a succinct description of the extent and character of the relationship between two variables, in this case I have used the Cramer's V whose range is between 0 and 1.0 and it makes them interpretable as a measure of the strength.

5.6 Level of Education.

| LEVEL OF EDUCATION | N | % |
|--------------------------------|------------|------------|
| No Formal Schooling | 44 | 6 |
| Primary School | 57 | 8 |
| Secondary School | 25 | 3 |
| Matric | 312 | 43 |
| University | 183 | 25 |
| Technical Diploma after Matric | 108 | 15 |
| Total | 729 | 100 |

Table 5.13: Highest level of education completed

The above table indicates that a large proportion of African asylum seeker and Refugees who come to South Africa are well educated with 43% having a Matric certificate (or equivalent), and 25% having a University certificate (either Undergraduate or post-graduate level) and 15% a Technical Certificate and we must bear in mind that refugee moves are composed almost exclusively of the well informed, well-to-do and well-educated individuals (Kunz 1981; Stein 1981).

| | Length of stay in South Africa | | | Total |
|--------------------|--------------------------------|-------------|-------------|------------|
| | % < 1 year | % 1-3 years | % > 4 years | |
| Primary or less | 16 | 12 | 10 | 14 |
| Secondary School | 3 | 4 | 3 | 3 |
| Matric | 39 | 49 | 46 | 43 |
| Tertiary or Higher | 42 | 36 | 41 | 40 |
| Total | 100 | 100 | 100 | 100 |
| N | 412 | 226 | 91 | 729 |

Table 5.14: Level of education by length of stay in South Africa

At first glance, the above table shows that the level of education of respondents is not affected by length of stay in South Africa. Moving from left to right, the level of education is fairly high (about 80%) in all the groups, either for those respondents who are in South Africa for less than one year, and for those who are in the country for more than four years. That is; the 87% of people who have been here longer consisted of a

sample size of 91 people, against the first group where the percentage of 81% is counted over a population of 412 people.

| LEVEL OF EDUCATION | GENDER | | Total |
|--------------------|------------|------------|------------|
| | %Male | %Female | |
| Primary or less | 13 | 16 | 14 |
| Secondary School | 3 | 4 | 3 |
| Matric | 45 | 31 | 43 |
| Tertiary or Higher | 38 | 48 | 40 |
| Total | 100 | 100 | 100 |
| N | 607 | 122 | 729 |

Table 5.15: Level of Education by sex

The data show that female respondents have a higher level of education, as 48% of them have a tertiary education qualification, against a 38% of the males. In the literature I did not find any theory on gender issues, but I can assume that such a value is dictated by pure chance, by serendipity, since the Cramer's V, which shows the strength of such relation, is only on a value of 16%.

| COUNTRY | EDUCATION LEVEL | | | | Total | N |
|--------------|-----------------|------------|-----------|-------------|------------|------------|
| | %<Primary | %Secondary | %Matric | %Tertiary + | | |
| Angola | 22 | 4 | 49 | 25 | 100 | 68 |
| Burundi | 21 | 13 | 29 | 38 | 100 | 24 |
| DRC | 10 | 1 | 36 | 52 | 100 | 231 |
| Rwanda | 9 | 5 | 36 | 50 | 100 | 22 |
| Somalia | 13 | 0 | 19 | 69 | 100 | 16 |
| Tanzania | 12 | 4 | 49 | 35 | 100 | 301 |
| Other | 25 | 4 | 46 | 24 | 100 | 67 |
| Total | 14 | 3 | 43 | 40 | 100 | 729 |

| Chi-Square Tests | Value |
|------------------------------|--------------|
| Pearson Chi-Square | 55.48 |
| Likelihood Ratio | 53.69 |
| Linear-by-Linear Association | 1.48 |
| Phi | 0.28 |
| Cramer's V | 0.16 |
| N of Valid Cases | 729 |

Tables 5.16: Level of education by country of origin

In my survey, I found that Somalis and Congolese from DRC are the most educated, and it is actually a surprise as a previous survey conducted by CASE and UNHCR in 2002, showed up the Somali community to be the community with the lowest level of education. The X^2 reveals that there is a certain relation between the two variables, nevertheless the extent is very low as the correlation coefficient (Cramer's V) shows 16% and so I can say that the country of origin does not affect the education level.

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5.7 Occupation and Employment

| OCCUPATION | N | % |
|---------------------------|------------|------------|
| Artist, Painting | 6 | 1 |
| Babysitter, Domestic | 13 | 2 |
| Barman, Waitress, Waitron | 11 | 2 |
| Blacksmith | 1 | 0 |
| Bricker | 22 | 3 |
| Cashier, Shop | 2 | 0 |
| Cleaning, Building | 40 | 5 |
| Clerks | 16 | 2 |
| Collector, Taxi | 2 | 0 |
| Cook | 2 | 0 |
| Dress Maker | 4 | 1 |
| Electrician | 6 | 1 |
| Furniture, removal | 7 | 1 |
| Hairdresser | 1 | 0 |
| Housekeeper | 1 | 0 |
| Mechanic | 2 | 0 |
| Musician, Street | 1 | 0 |
| Painter | 17 | 2 |
| Parking, Attendant | 17 | 2 |
| Plumber | 3 | 0 |
| Printer | 1 | 0 |
| Security Guard | 78 | 11 |
| Sewer | 2 | 0 |
| Shopkeeper | 20 | 3 |
| Street Vendor, non-food | 42 | 6 |
| Taxi driver, Owner | 78 | 11 |
| Truck Driver | 16 | 2 |
| Unemployed | 299 | 41 |
| Worker, non Farm | 19 | 3 |
| Total | 729 | 100 |

Table 5.17: What is your current occupation?

The present survey does not take into account the occupational status before the arrival in South Africa. What we can see, from the above table, is the great rate of unemployed, which is 41%, against the 24% analyzed in the previous survey conducted by the UNHCR and CASE. We can see that in the Cape Town Area the unemployment rate is almost double the one found in the UNHCR survey conducted in 2002.

| CATEGORY | N | % |
|--------------------------------------|------------|------------|
| Clerks | 14 | 3 |
| Service, Workers and shop and market | 38 | 9 |
| Craft and related trades workers | 49 | 11 |
| Elementary Occupation | 316 | 73 |
| Domestic jobs | 13 | 3 |
| Total | 430 | 100 |

Table 5.18: Current occupation by level of skills (*The categories are the ones used in the Survey on Labour Force 2006, Statistics South Africa*)

As we can see from the table above, 73% of the respondents are employed in elementary occupations which groups Parking Attendant, Plumber, General Worker, House Keeper, Painter, Security Guard, Furniture Remover and Hair Dresser³.

| CATEGORY | GENDER | | |
|--------------------------------------|---------------|----------------|--------------|
| | %Male | %Female | Total |
| Clerks | 2 | 2 | 2 |
| Service, Workers and shop and market | 6 | 1 | 5 |
| Craft and related trades workers | 7 | 5 | 7 |
| Elementary Occupation | 48 | 22 | 43 |
| Domestic jobs | 0 | 11 | 2 |
| Unemployed | 37 | 59 | 41 |
| Total | 100 | 100 | 100 |
| N | 607 | 122 | 729 |

Table 5.19: Current occupation according to level of skills by gender

By crossing the work categories by the gender of the respondents, we can see that the proportion of Unemployed is greater for women (60%) than for men (37%), while in the elementary occupation almost 50% of men are grouped in contrast with a 20% of women who are more likely to be clustered in domestic jobs.

³The category groups all these above as no training course was mentioned during the interview process

| CATEGORY | ENGLISH LEVEL | | | | Total | N |
|--------------------------------------|------------------|-----------|-----------|------------|------------|------------|
| | %Mother language | %Poor | %Good | %Excellent | | |
| Clerks | 0 | 86 | 0 | 14 | 100 | 14 |
| Service, Workers and shop and market | 76 | 13 | 11 | 0 | 100 | 38 |
| Craft and related trades workers | 57 | 29 | 14 | 0 | 100 | 49 |
| Elementary Occupation | 58 | 23 | 16 | 3 | 100 | 316 |
| Domestic jobs | 0 | 23 | 77 | 0 | 100 | 13 |
| Unemployed | 36 | 40 | 20 | 3 | 100 | 299 |
| Total | 48 | 31 | 18 | 3 | 100 | 729 |

Table 5.20: Fluency in English by category of occupation

In the above table we can see that there is no correlation between the fluency in English and the category of occupation, as the proportion of unemployed does not have a great variation for the respondents who declared English as their mother tongue (36%) and those respondents with a poor level of English (40%). The 76% of respondents who have English as Mother language are grouped in the second category, but apart this data we can assume that language is not a requisite for the exclusion from these jobs, as these are all Unskilled jobs. What we can conclude is that refugees are actually part of that labour force which competes with local South Africans thanks to the cheap labour that they can provide and their desperation for a job and possible higher level of education might be a factor that offsets the language disadvantage.

5.8 Income Level

| COUNTRY | Monthly INCOME | | | |
|--------------|----------------|------------|----------|--------------|
| | Mean | Median | Minimum | Maximum |
| Angola | 779 | 700 | 0 | 5000 |
| Burundi | 319 | 0 | 0 | 1500 |
| DRC | 566 | 0 | 0 | 3000 |
| Rwanda | 195 | 0 | 0 | 1500 |
| Somalia | 1781 | 1500 | 0 | 7000 |
| Tanzania | 2477 | 800 | 0 | 20000 |
| Other | 933 | 0 | 0 | 10000 |
| Total | 1416 | 700 | 0 | 20000 |

Table 5.21: Per capita monthly income by country of origin

The table reported above shows that the mean monthly per capita income for my sample was 1416R, whereas the median value was 700R. Considering that there were a few cases where household income was quite high, the median value is likely to be more reliable, so that this measure indicates that each person in a household is likely to have access to approximately 700R each month; in the previous survey conducted by the UNHCR and CASE the median value was 650R on a national base for the refugee population and my survey shows an increase of 11% compared with the value of 2002, but keeping up with inflation in real terms it should be and increase of about 30%. Hence income for my respondents might, on average, be considerably lower than the national average for SA.

| Income by Gender | Mean ⁴ | N | Std. Deviation |
|------------------|-------------------|-----|----------------|
| Male | 4 | 380 | 2 |
| Female | 2 | 50 | 1 |
| Total | 3 | 430 | 2 |

Table 5.22: Per capita monthly income by gender

In terms of gender, the income gap between men and women is quite marked, as we can see from the table above (Table 5.22); men tend to have a monthly income between R1,500 and R2,000, against women who have a monthly income between R500 and R1,000, the gender inequity is explained by looking at the tables referring to age and occupation; as was noted, women tend to be younger than men and the are mainly ranked

⁴ The values of the means refer to the Income Group: 2=R500-R1000; 3=R1,000-R1,500; 4=R1,500-R2,000

amongst the category unemployed (59%); while 33% of them are employed in elementary and domestic jobs.

Conclusions

These findings show that asylum seekers and refugees in Cape Town tend to be relatively young, with an average age of 29 years. About half of the respondents, predominantly males, were single against 46% who were married, showing an increase of 50% with regard to the 2002 survey, even though my survey has not taken into account whether respondents are currently living with their partner.

It is a sensitive data that the fluency in English is very low, showing a total reversal to the previous survey, as my findings show a 60% rate of poor level in English; in the previous survey the percentage of respondent with a low English level was only 34%.

Nearly unchanged is the educational level as also my findings have revealed that the 83% of the respondents completed either matric or a tertiary education, against a 64% in a nationally based survey of 2002.

Almost unchanged is the situation regarding the occupation where I found 41% of unemployed and among those respondents who have revealed to have a job the 73% is ranked in the category “Elementary Occupations”, a data which revealed the impossibility for asylum seekers and refugees to exercise their educational skills.

The income level per capita is higher than the 2002 value, being R700 per capita.

As we can see from the analysis of the demographic details, the refugee population seems not to be very different in composition from the so-called “economical migrants”; in both cases the population is very young, thus reflecting the process of job search which is seen to be common to both categories of migrants. Another common element is the social and family network used in the decision making of migrating. The high educational level shows that only the well-educated and the well-to-do individuals are likely to migrate as is shown in different researches (Dal Lago 2005; Pollini & Scida’ 2002; Ritchey 1986). Despite their high skill levels, the refugee population, as well as those who migrate for economical reasons, are encapsulated in a second labour market of unskilled jobs and lower salaries (Dal Lago 2005), and despite the different push factors both choose their destination on a social network base (family and friends who already live in a host

country), and their choice is rational and dictated from the hope for a better life, and the hope to support their family left in their own country.

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5.9 Access to Healthcare

As we can see from the tables below, we can try to determine which type of health issues the Refugees are facing within the South African context.

The table 5.23 shows that the top four reasons for requiring Health Cares are: General consulting for 97% of the interviewees, followed by Pharmacy and Treatment (57%), then Trauma Counseling (44%) and finally Emergency Treatment (32%). Less than 30% have access to health care for HIV/AIDS treatment or testing and only the 2% of them have used contraception treatment. If we look at the table by country of origin we can see that as for general counseling the values are quite high and involving 95-100% of the population; Pharmacy reasons, despite interesting half of refugees country by country, have its peak for refugees from Burundi (76%) and from Somalia (75%); as far as Trauma counseling is concerned we can see that it interests half of the respondents from Rwanda (48%), Somalia (42%) and Tanzania (49%) due to the political situation they escaped in their country; the genocide of 1994 for the first, and the troubled political situation of the last two. Emergency treatments involve mainly Angolan refugees (44%) while the other countries have similar percentage nearly 30%. HIV/AIDS counseling interests mainly Angolans (51%).

| % | GENERAL COUNS | PHARMACY | TRAUMA | EMERGENCY | EYE CARE | HIV/AIDS | IMMUNIZ. | CONTRACC. |
|--------------|------------------|-----------|-----------|-----------|-------------|-----------|-----------|-----------|
| Angola | 100 | 51 | 22 | 44 | 0 | 51 | 0 | 0 |
| Burundi | 100 | 76 | 38 | 33 | 48 | 29 | 0 | 10 |
| DRC | 95 | 54 | 37 | 31 | 23 | 26 | 20 | 0 |
| Rwanda | 95 | 19 | 48 | 38 | 38 | 29 | 0 | 0 |
| Somalia | 100 | 75 | 42 | 33 | 33 | 0 | 25 | 0 |
| Tanzania | 100 | 58 | 49 | 28 | 35 | 19 | 22 | 0 |
| Other | 89 | 68 | 68 | 32 | 33 | 38 | 17 | 17 |
| Total | 97 | 57 | 44 | 32 | 28 | 27 | 18 | 2 |

Table 5.23 Reason for accessing Health Care by Country of origin

The following table (Table 5.24) shows that almost 70% of the interviewees have visited Public Hospitals and, by contrast, only a 14% have visited private Hospital Institutions. Muslim doctors were visited by only 16% of the respondents and traditional healers by only 1% of refugees. By testing the latter variable we can see that by religion, 34% of

Muslims chose to refer to Muslim doctors either in a public or in a private institution; while Christian respondents did not specify a particular kind of doctor and refer either to a public or to a private hospital. The high Cramer's V value (47%) suggests the strong relation between chosen institution and religion.

| INSTITUTION | N | % |
|--------------------|------------|------------|
| Public Hospital | 417 | 68 |
| Private Hospital | 85 | 14 |
| Traditional Healer | 7 | 1 |
| Muslim Doctor | 100 | 16 |
| Total | 609 | 100 |

Table 5.24: Where were you referred to?

| INSTITUTION | RELIGION | | Total |
|--------------------|-------------------|----------------|--------------|
| | %Christian | %Muslim | |
| Public Hospital | 84 | 52 | 68 |
| Private Hospital | 16 | 12 | 14 |
| Traditional Healer | 0 | 2 | 1 |
| Muslim Doctor | 0 | 34 | 16 |
| Total | 100 | 100 | 100 |
| N | 312 | 297 | 609 |

| | Value |
|-------------------|--------------|
| Phi | 0.47 |
| Cramer's V | 0.47 |

Table 5.25: Health Institution by religious confession

Almost half the interviewees (Table 5.26) have been guided by Family and Friends in choosing the institution to go to when they were in need of Health Care, and only 10% have been guided by one of the NGO's, while for 22% of them the problem of money has been the reason for their choice. Among those who opted for a Public Institution, 50% have been guided by Family and Friends and 31% by money issues, only 14% referred to NGO's. Those ones who chose to go to a Private Institution, complained that there was a problem with their status (38%) and 35% opted for the Private sector thanks to its better service.

| INSTITUTION | WHY DID YOU GO THERE? | | | | | | Total | N |
|--------------------|-----------------------|------------|-----------|------------|-----------------|-----------|------------|------------|
| | %Family/friends | %Newspaper | %Money | %No Permit | %Better Service | %NGO's | | |
| Public Hospital | 50 | 1 | 31 | 3 | 0 | 14 | 100 | 417 |
| Private Hospital | 27 | 0 | 0 | 38 | 35 | 0 | 100 | 85 |
| Traditional Healer | 71 | 0 | 0 | 0 | 29 | 0 | 100 | 7 |
| Muslim Doctor | 13 | 0 | 0 | 13 | 74 | 0 | 100 | 100 |
| Total | 41 | 0 | 22 | 10 | 18 | 10 | 100 | 609 |

Table 5.26: Reason to choose such institution by chosen institution

The tables 5.27, on the next page, shows that the top five problems experienced by the interviewees in accessing Healthcare are related mainly to a linguistic barrier (64%), followed by encountering what refugees called “rude hospital staff” and money issues (61%), and finally the problems of the permit which have not been recognized (54%) and, related to this, the problem of fear of being turned away (48%). As for linguistic barrier it seems that the more affected were Angolans (93%) Rwandans and Congolese (86%) and Somalis (100%); and the latter seem to have encounter problems due to a rude staff (100%) more than the other refugees; the same issue seems to affect Burundians (71%) as well. As far as financial troubles are concerned it seems that Rwandans and Tanzanians are the more affected: 73% the former and 69% the latter.

| % Values | LANGUAGE | RUDE STAFF | MONEY | PERMIT ISSUES | FEAR TO BE TURNED AWAY | OPEN TIME | TRANSPORT | N |
|-----------------|-----------------|-------------------|--------------|----------------------|-------------------------------|------------------|------------------|------------|
| Angola | 93 | 42 | 47 | 36 | 39 | 41 | 7 | 59 |
| Burundi | 76 | 71 | 24 | 38 | 33 | 19 | 5 | 21 |
| DRC | 86 | 57 | 55 | 46 | 40 | 27 | 22 | 197 |
| Rwanda | 86 | 67 | 76 | 67 | 52 | 52 | 5 | 21 |
| Somalia | 100 | 100 | 42 | 67 | 75 | 75 | | 12 |
| Tanzania | 36 | 59 | 69 | 59 | 50 | 41 | 33 | 236 |
| Other | 54 | 84 | 71 | 71 | 70 | 46 | 38 | 63 |
| Total | 64 | 61 | 61 | 54 | 48 | 37 | 25 | 609 |

Table 5.27: Reason that prevents from getting Healthcare by Country of Origin

| % Values | HEALTH RISK | | | | | | N |
|-----------------|--------------------|---------------------|------------------------------|----------------|-------------------------------|---------------------------------|------------|
| | POVERTY | UNEMPLOYMENT | BAD LIVING CONDITIONS | NO INFO | BAD WORKING CONDITIONS | DIFFICULTY IN EXPLAINING | |
| Angola | 94 | 97 | 99 | 96 | 79 | 100 | 68 |
| Burundi | 54 | 67 | 88 | 63 | 71 | 83 | 24 |
| DRC | 77 | 78 | 78 | 70 | 59 | 71 | 231 |
| Rwanda | 50 | 50 | 50 | 50 | 50 | 95 | 22 |
| Somalia | 75 | 81 | 63 | 63 | 56 | 94 | 16 |
| Tanzania | 93 | 88 | 84 | 25 | 20 | 5 | 301 |
| Other | 97 | 91 | 76 | 81 | 70 | 34 | 67 |
| Total | 86 | 84 | 81 | 53 | 46 | 45 | 729 |

Table 5.28: Health Risk by Country of Origin

Below, I have reported the tables (5.29-5.30) referring to the network that the interviewees have followed in accessing healthcares. We can see that the 84% of them have preferred relying on members of their own community, followed by 71% who referred to local pharmacies and 51% who had the support of local South Africans, a surprising finding as in the UNHCR's survey⁵ the percentage of those who referred to local South Africans was only 11%. Lastly, only 13% of the interviewees have revealed relying on local NGO's for Health matters, a finding that I already noted in Chapter 4.

| WHO DO YOU RELY ON WHEN YOU NEED MEDICAL ASSISTANCE? | | | | | | |
|---|----------------------|-----------------|----------------------|----------------|--------------|------------|
| | COMM. MEMBERS | PHARMACY | LOCAL FRIENDS | DOCTORS | NGO'S | N |
| Angola | 90 | 51 | 18 | 60 | 0 | 68 |
| Burundi | 83 | 63 | 46 | 83 | 50 | 24 |
| DRC | 65 | 65 | 27 | 63 | 16 | 231 |
| Rwanda | 73 | 86 | 55 | 45 | 32 | 22 |
| Somalia | 94 | 94 | 50 | 69 | 19 | 16 |
| Tanzania | 95 | 88 | 79 | 20 | 6 | 301 |
| Other | 93 | 60 | 43 | 55 | 21 | 67 |
| Total | 84 | 74 | 51 | 45 | 13 | 729 |

Table 5.29 Where do you refer to by Country of Origin

⁵UNHCR & JICA, 2003, National Refugee baseline survey: Final Report, Community Agency for Social Enquiry, pp. 142-151

| | INFORMATION | | | | | N |
|--------------|-------------------|-----------|---------------|----------------|------------|------------|
| | Health Care Inst. | NGO | UCT Legal Aid | Family/Friends | Total | |
| Angola | 97 | 0 | 0 | 3 | 100 | 68 |
| Burundi | 83 | 17 | 0 | 0 | 100 | 24 |
| DRC | 77 | 15 | 2 | 6 | 100 | 231 |
| Rwanda | 68 | 32 | 0 | 0 | 100 | 22 |
| Somalia | 81 | 13 | 0 | 6 | 100 | 16 |
| Tanzania | 63 | 14 | 0 | 23 | 100 | 301 |
| Other | 72 | 18 | 0 | 10 | 100 | 67 |
| Total | 73 | 14 | 1 | 12 | 100 | 729 |

Table 5.30: Where do you currently get health information by Country of Origin

The above table (5.30) reports that the 73% of the interviewees get information about healthcare providers directly from healthcare institutions, and only the 14% of them refer to organizations which work with refugees. In the next table (5.31) I have reported on which places the interviewees would like to get information from. The highest percentage reported NGO's as the main place where they would like to get more information about healthcare providers, followed by Home Affairs (18%) and then directly from healthcare institutions (16%); the family and community network are the last position as only the 4% of them would like to rely on them. This data shows the great interest from the refugees' point of view in feeling part of the South African context by following governmental channels in their decision making.

| INFORMATION 2 | N | % |
|----------------------------|------------|------------|
| NGO's | 160 | 22 |
| Home Affairs | 132 | 18 |
| State Health Organizations | 117 | 16 |
| Do not Know | 102 | 14 |
| Refugee Clinic | 90 | 12 |
| TV/Radio | 64 | 9 |
| UNHCR | 37 | 5 |
| Own Community Organization | 27 | 4 |
| Total | 729 | 100 |

Table 5.31: Where would you like to get information?

Conclusions

The findings regarding the medical choice reveal some particular features; first of all the refugee population is mainly referring to medical assistance for primary healthcare; in their choice they largely rely on public institutions (68%) and as was noted this is a choice influenced by social networks which refugees are able to build in South Africa within their own communities; this is a feature common to many refugee studies and researches I noticed in literature (Ritchey 1976; Kunz 1981; Finnan 1981; Stein 1981; Jacobsen 1996): we typically find that refugees refer to different health institution on friends and own community members' suggestions. The interesting pattern is given by the influence that is determined by the religion confession and, mainly for Muslim communities; there is the need to find Muslim practitioners. Surprising is the growing of local social networks and the fact that refugees are relying on South African citizens when in need of medical help; this is surprising as in the previous research conducted by the UNHCR in 2002, I noticed that such a percentage was only 11% against 51% of my research. Language, rude staff, financial issues and difficulties related to their formal recognition and to their permit are still problems for more than a half of the respondents despite the role of several NGO's in educating the medical staff on refugees' issues in different state hospital in Cape Town.

Surprising is the will of refugees to rely on government channels to get information; the last table (5.31) shows that Home Affairs and state health organizations are the main sources of information on which refugees would like to rely.

CONCLUSIONS AND RECOMMENDATIONS

In concluding my study I want to highlight the two main findings I obtained: the first relates to the theory which links migration and refugees studies; and the second relates to the main problems which refugees are facing in terms of exclusion from social, political and economical benefits in South Africa.

On a theoretical level the refugee population does not differ very much from those who migrate for economical reasons, thus many of the features of both populations seem to be common, underlining the fine line between the two groups, too often approached as two different types of migrants. As Hein (1993) postulated, the demographic variables (gender, age, education, occupation and income) related to migration studies *tout court* reveal similar backgrounds: as my findings show, the population is mainly composed of young males (26-30 years old) underlining the process of job search which I assumed being an important push factor besides the forced political situation which led refugees to escape their homelands. Their level of education, as I found, is quite high underlining the fact that only the well educated and the well informed are able to undertake the flight to another country, a finding that led me to conclude, despite the fact that I did not investigate the social background of the respondents in their homeland, that the refugee population is composed mainly of people originally coming from a middle-class context. As the literature shows (Dal Lago 2005; Vincenzi 2000), migrants (with no regard to the reasons of their move) are often encapsulated into a second labour market made of unskilled jobs and, as my findings revealed, the refugee population is segregated into a category of elementary occupations with an average monthly income well below the poverty line. Such a feature is common to a lot of migrants in Europe and the USA as Dal Lago (2005) and Vincenzi (2000) showed.

Problems become more serious as we examine the extent of exclusion from the welfare system and specifically from healthcare facilities.

The issues which affect the refugee population are often linked to three main problems: the delays at the Department of Home Affairs in obtaining the permit which forces refugees to rely on unaffordable private healthcare; the second problem, often highlighted by the NGO's, relates to a lack of education within the Health Department on refugee issues which is expressed through what the refugees refer as "rude staff" and linked

mainly to a lack of knowledge regarding their permits which often result in an unjustified rejection from public institutions; and the third problem is relates to a deep linguistic barrier which results in poor treatment of their medical condition.

In 2005 students of the 4th year at UCT Medical School analysed the medical situation of refugees in the Woodstock area and as a result of the recognition of the language barrier, the Woodstock Clinic, following the Scalabrini Refugee Service and Trauma Centre's suggestion, decided to adopt a system using boards on which the symptoms were translated from French and Portuguese into English in order to let refugees explain their problems in their own language by indicating them on those boards and letting practitioners understand them through the English translation This strategy was adopted because of the serious lack of funds of the NGOs that prevented them from employing translators in the main state hospitals to which refugees mainly refer.

Until November 2007 those refugees who had only the Appointment slip were not recognized in public hospitals as this slip of paper did not have any legal significance, so that the only option, for many of them was to rely on the expensive private sector which is unaffordable for them. Unfortunately my data are limited to a period prior the recognition of the Appointment slip, so one of my recommendations is that research be continued on the same topic to see if actually refugees, even those without any kind of permit (S.22; S.24), will benefit of healthcares since they are constitutionally entitled to it. Another suggestion is to improve the quality of service at government level by employing more translators within the health institutions in order to treat refugees fairly and humanely and clearly to simplify the process to obtain the necessary papers to live in South Africa.

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QUESTIONNAIRE FOR REFUGEES

DEMOGRAPHIC INFORMATION

| | | |
|----|---|-------|
| 1 | IDENTITY | 1 |
| | | ----- |
| 2. | Gender | 2 |
| | Male [1] Female [2] | ---- |
| 3. | Age | 3 |
| | | ----- |
| 4. | Marital status | 4 |
| | Single [1] Married [2] Widow [3] Divorced [4] | ----- |
| 5. | Country of origin | 5 |
| | Angola [1] | ----- |
| | Burundi [2] | |
| | Cameroon [3] | |
| | Congo Brazzaville [4] | |
| | DRC [5] | |
| | Ethiopia [6] | |
| | Ivory Coast [7] | |
| | Kenya [8] | |
| | Liberia [9] | |
| | Malawi [10] | |
| | Mozambique [11] | |
| | Nigeria [12] | |
| | Rwanda [13] | |
| | Senegal [14] | |
| | Sierra Leone [15] | |
| | Somalia [16] | |
| | Sudan [17] | |
| | Tanzania [18] | |
| | Uganda [19] | |
| | Zambia [20] | |
| | Zanzibar [21] | |
| | Zimbabwe [22] | |
| 6. | Do You have children? | 6 |
| | Yes [1] No [2] | ----- |
| 7. | If Yes, How many? | 7 |
| | | ----- |

APPENDIX 1

8. In which area of Cape Town do You live?

8

9 .Which language do You speak?

9-17

- 9 English Yes [1] No [2]
- 10 French Yes [1] No [2]
- 11 Portuguese Yes [1] No [2]
- 12 Swahili Yes [1] No [2]
- 13 Somali Yes [1] No [2]
- 14 Lingala Yes [1] No [2]
- 15 Kin Rwanda Yes [1] No [2]
- 16 Kirundi Yes [1] No [2]
- 17 Other

18. (If no English Mother Language)What is Your English level?

18

Poor [1] Good [2] Excellent [3]

19. If You speak one of the following language, what do You think is Your level in this/these language/s?

19-28

- 19 Afrikaans NA [0] Poor [1] Good [2] Excellent [3]
- 20 IsiXhosa NA [0] Poor [1] Good [2] Excellent [3]
- 21 IsiZulu NA [0] Poor [1] Good [2] Excellent [3]
- 22 Ndebele NA [0] Poor [1] Good [2] Excellent [3]
- 23 Sepedi NA [0] Poor [1] Good [2] Excellent [3]
- 24 Sesotho NA [0] Poor [1] Good [2] Excellent [3]
- 25 Siswati NA [0] Poor [1] Good [2] Excellent [3]
- 26 Setswana NA [0] Poor [1] Good [2] Excellent [3]
- 27 Xitsonga NA [0] Poor [1] Good [2] Excellent [3]
- 28 Tshivenda NA [0] Poor [1] Good [2] Excellent [3]

| | | |
|---|----------------------|-------|
| 29. What is Your religion? | | 29 |
| | | ----- |
| Christian | Catholic | [1] |
| | Methodist | [2] |
| | Seven Days Adventist | [3] |
| | Orthodox | [4] |
| | Anglican | [5] |
| | Protestant | [6] |
| | Jehovah's witness | [7] |
| | Jubilee Church | [8] |
| | Pentecost Church | [9] |
| Muslim | Sciia | [9] |
| | Sunni | [10] |
| Hindu | | [11] |
| Other | | [12] |
| Refuse to answer | | [88] |
| 30. Are You in South Africa for less than a year? | | 30 |
| | | ----- |
| NA | [0] | |
| 1-3 months | [1] | |
| 3-6 months | [2] | |
| 6-9 months | [3] | |
| Up to 1 year | [4] | |
| 31. If more than one year, how many years? | | 31 |
| | | ----- |
| NA | [0] | |
| 32. Did You go to school in Your Country? | | 32 |
| | | ----- |
| Yes | [1] | |
| No | [2] | |
| 33. If Yes, How many years did You attend? | | 33 |
| | | ----- |
| NA | [0] | |

APPENDIX 1

NA [0] Asylum seeker (S.22) [1] Refugee (S.24) [2] Permanent Residence (S.27) [3]

47. If No, do You have any Appointment? 47

NA [0] Yes[1] No [2]

HEALTH NEEDS

48. Since You have been in South Africa, have You ever needed to see a doctor? 48

Yes [1] No [2]*

*IF "NO" go to Point 69

49. If Yes, for which reason? 49-56

| | | | |
|-----------------------------------|--------|---------|--------|
| 49 Pharmacy | NA [0] | Yes [1] | No [2] |
| 50 Emergency Treatment | NA [0] | Yes [1] | No [2] |
| 51 Immunization | NA [0] | Yes [1] | No [2] |
| 52 Contraception | NA [0] | Yes [1] | No [2] |
| 53 HIV/AIDS Testing and Treatment | NA [0] | Yes [1] | No [2] |
| 54 Trauma and grief counseling | NA [0] | Yes [1] | No [2] |
| 55 General counseling | NA [0] | Yes [1] | No [2] |
| 56 Other..... | NA [0] | Yes [1] | No [2] |

57. Where did You mainly go? (Only one answer) 57

NA [0]
Public Hospital/clinic [1]
Private Hospital/clinic [2]
Other..... [3]

58. Why did You choose to go there? 58

NA [0]
Family and/or Friends' advice [1]
Newspaper [2]
Other..... [3]

59. How would You rate the health care that You received? 59

NA [0] Poor [1] Satisfactory [2] Good [3] Excellent [4]

60. If poor, why? 60

NA [0]

.....

| | | | |
|-----|---|-----------------------|-------|
| 61. | What problems have you experienced that prevent you from getting health cares | | 61-68 |
| | | | ----- |
| | 61 Don't understand the language | NA [0] Yes [1] No [2] | |
| | 62 Cost of getting health care | NA [0] Yes [1] No [2] | |
| | 63 Transport to clinic | NA [0] Yes [1] No [2] | |
| | 64 Afraid of being turned away | NA [0] Yes [1] No [2] | |
| | 65 Opening times of the clinic | NA [0] Yes [1] No [2] | |
| | 66 Rude staff | NA [0] Yes [1] No [2] | |
| | 67 Permit | NA [0] Yes [1] No [2] | |
| | 68 Don't know where to go | NA [0] Yes [1] No [2] | |
| 69. | Where do You currently get information about Health care? | | 69 |
| | | | ----- |
| | Public/private Hospitals | [1] | |
| | Public/Private clinics | [2] | |
| | NGO's | [3] | |
| | Other..... | [4] | |
| 70. | Where would You like to get information about Your Health care needs? | | 70 |
| | | | ----- |
| 71. | Which of these factors do you think are very risky for Your Health? | | 71-77 |
| | | | ----- |
| | 71 Bad work condition | Yes [1] No [2] | |
| | 72 Bad living condition | Yes [1] No [2] | |
| | 73 Lack of Information | Yes [1] No [2] | |
| | 74 Difficulties in explaining Your issues | Yes [1] No [2] | |
| | 75 Poverty | Yes [1] No [2] | |
| | 76 Unemployment | Yes [1] No [2] | |
| | 77 Other..... | Yes [1] No [2] | |
| 72. | Who are You referring to when You feel sick? | | 78-83 |
| | | | ----- |
| | 78 Friends from Your Community | Yes [1] No [2] | |
| | 79 Local friends | Yes [1] No [2] | |
| | 80 Pharmacy | Yes [1] No [2] | |
| | 81 Doctor | Yes [1] No [2] | |
| | 82 Organizations for Refugees | Yes [1] No [2] | |
| | 83 No one | Yes [1] No [1] | |

APPENDIX 2

QUESTIONNAIRE POUR LES RÉFUGIÉS

INFORMATION DÉMOGRAPHIQUE

| | | |
|----|--|-------|
| 1 | IDENTITÉ | 1 |
| | | ----- |
| 2. | Genre/Sexe | 2 |
| | Homme [1] Femme [2] | ----- |
| 3. | Âge | 3 |
| | | ----- |
| 4. | Statut marital | 4 |
| | Célibataire [1] Marié(e) [2] Veuf(ve) [3] Divorcé(e)[4] | ----- |
| 5. | Pays d'origine | 5 |
| | ----- | |
| | Angola [1] | |
| | Burundi [2] | |
| | Cameroun [3] | |
| | Congo Brazzaville [4] | |
| | RDC [5] | |
| | Éthiopie [6] | |
| | Côte d'Ivoire [7] | |
| | Kenya [8] | |
| | Liberia [9] | |
| | Malawi [10] | |
| | Mozambique [11] | |
| | Nigéria [12] | |
| | Rwanda [13] | |
| | Sénégal [14] | |
| | Sierra Leone [15] | |
| | Somalie [16] | |
| | Soudan [17] | |
| | Tanzanie [18] | |
| | Ouganda [19] | |
| | Zambie [20] | |
| | Zanzibar [21] | |
| | Zimbabwe [22] | |
| 6. | Avez-vous des enfants? | 6 |
| | Oui [1] Non [2] | ----- |

APPENDIX 2

| | | | | | | |
|---|---------------|------------|---------------|---------------|--|-------|
| 7. Si oui, combien? | | | | | | 7 |
| | | | | | | ----- |
| 8. Dans quel quartier de Cape Town habitez-vous? | | | | | | 8 |
| | | | | | | ----- |
| 9. Quelles langues parlez-vous? | | | | | | 9-17 |
| | | | | | | ----- |
| 9 Anglais | Oui [1] | Non [2] | | | | |
| 10 Français | Oui [1] | Non [2] | | | | |
| 11 Portugais | Oui [1] | Non [2] | | | | |
| 12 Swahili | Oui [1] | Non [2] | | | | |
| 13 Somali | Oui [1] | Non [2] | | | | |
| 14 Lingala | Oui [1] | Non [2] | | | | |
| 15 Kin Rwanda | Oui [1] | Non [2] | | | | |
| 16 Kirundi | Oui [1] | Non [2] | | | | |
| 17 Autre | | | | | | |
| 18. (Si l'anglais n'est pas votre langue maternelle) Comment estimez-vous votre niveau d'anglais? | | | | | | 18 |
| | | | | | | ----- |
| | Faible [1] | Bon [2] | Excellent [3] | | | |
| 19. Si vous parlez l'une des langues suivantes, quel niveau estimez-vous avoir? | | | | | | 19-28 |
| | | | | | | ----- |
| 19 Afrikaans | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 20 IsiXhosa | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 21 IsiZulu | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 22 Ndebele | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 23 Sepedi | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 24 Sesotho | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 25 Siswati | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 26 Setswana | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 27 Xitsonga | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |
| 28 Tshivenda | non parlé [0] | Faible [1] | Bon [2] | Excellent [3] | | |

APPENDIX 2

| | | |
|---|-------------------------|-------|
| 29. Quelle est votre religion? | | 29 |
| | | ----- |
| Chrétienne | Catholique | [1] |
| | Méthodiste | [2] |
| | Seventh Day's Adventist | [3] |
| | Orthodoxe | [4] |
| | Anglican | [5] |
| | Protestant | [6] |
| | Témoign de Jéhovah | [7] |
| | Jubilee Church | [8] |
| | Église Pentecôtiste | [9] |
| | | |
| Musulmane | Chiite | [9] |
| | Sunnite | [10] |
| | | |
| Hindou | | [11] |
| | | |
| Autre | | [12] |
| | | |
| Ne souhaite pas répondre | | [88] |
| | | |
| 30. Êtes-vous en Afrique du Sud depuis moins d'un an? | | 30 |
| | | ----- |
| non | [0] | |
| entre 1 et 3 mois | [1] | |
| entre 3 et 6 mois | [2] | |
| entre 6 et 9 mois | [3] | |
| entre 9 mois et 1 an | [4] | |
| | | |
| 31. Si plus d'un an, combien d'année? | | 31 |
| | | ----- |
| | | |
| 32. Êtes-vous allé à l'école dans votre pays? | | 32 |
| | | ----- |
| Oui [1] Non [2] | | |
| | | |
| 33. Si oui, combien d'années y avez-vous étudié? | | 33 |
| | | ----- |
| | | |
| 34. Quel est le diplôme le plus élevé que ayiez obtenu dans votre pays? | | 34 |
| Aucun [0] | | ----- |

APPENDIX 2

| | |
|---|------------------------------------|
| 35. Quelle est actuellement votre activité en Afrique du Sud? | 35-37 |
| 35 Travail | Oui [1] Non [2] |
| 36 Études | Oui [1] Non [2] |
| 37 Rien | Oui [1] Non [2] |
| 38. Si vous travaillez, quel est votre emploi? | 38 |
| Aucun [0] | ----- |
| | |
| 39. Avez-vous l'un des contrats de travail suivants? | 39 |
| Aucun [0] À durée déterminée [1] À durée indéterminée [2] ne souhaite pas répondre [88] | ----- |
| 40. Quel est (à peu près) votre revenu mensuel? | 40 |
| Aucun [0] | ----- |
| 41. Si vous n'avez aucun revenu, qui vous supporte? | 41-43 |
| 41 Votre famille | pas de famille [0] Oui [1] Non [2] |
| 42 Vos amis | pas d'amis [0] Oui [1] Non [2] |
| 43 Autres..... | [0] Oui [1] Non [2] |
| 44. Avez-vous des membres de votre famille résidant à Cape Town? | 44 |
| Oui [1] Non [2] | ----- |
| 45. Avez-vous un permis de résidence en Afrique du Sud? | 45 |
| Oui [1] Non [2] | ----- |
| 46. Si oui, lequel? | 46 |
| Aucun [0] Demandeur d'Asile (Section 22) [1] Réfugié (Section 4) [2] | ----- |
| Résidence Permanente (Section 27) [3] | |

APPENDIX 2

47. Si non, avez-vous un rendez-vous pour en obtenir un? 47

NA [0] Oui [1] Non [2]

BESOINS MÉDICAUX

48. Depuis votre arrivée en Afrique du Sud, avez-vous eu besoin de voir un docteur? 48

Oui [1] Non [2]*

* Si "NON", allez directement à la question 69

49. Si "OUI", pour quelle raison? 49-56

| | | | |
|--|--------|---------|---------|
| 49 Besoin de médicaments | NA [0] | Oui [1] | Non [2] |
| 50 Traitement d'urgence | NA [0] | Oui [1] | Non [2] |
| 51 Vaccination | NA [0] | Oui [1] | Non [2] |
| 52 Contraception | NA [0] | Oui [1] | Non [2] |
| 53 Test de séropositivité (SIDA) et traitement | NA [0] | Oui [1] | Non [2] |
| 54 Traumatisme et suivi psychologique | NA [0] | Oui [1] | Non [2] |
| 55 Conseil général | NA [0] | Oui [1] | Non [2] |
| 56 Autre..... | NA [0] | Oui [1] | Non [2] |

57. Où êtes-vous allé? (seulement une réponse) 57

| | |
|---------------------------|-----|
| NA | [0] |
| Hôpital/Clinique publique | [1] |
| Hôpital/Clinique privé(e) | [2] |
| Autre..... | [3] |

58. Pourquoi avez-vous choisi d'aller à cet endroit? 58

| | |
|---|-----|
| NA | [0] |
| Sur le conseil d'un ami ou d'un membre de votre famille | [1] |
| Vous avez connu cet endroit en lisant le journal | [2] |
| Autre..... | [3] |

59. Comment jugez-vous la qualité des soins que vous avez reçus? 59

NA [0] Faible [1] Satisfaisante [2] Bonne [3] Excellente [4]

60. Si "FAIBLE", pourquoi? 60

NA [0]
.....

APPENDIX 2

61. Quels problèmes avez-vous rencontrés, qui vous ont empêché de recevoir les services de santé dont vous aviez besoin ?

61-68

| | |
|--|------------------------|
| 61 la barrière de la langue | NA [0] Oui [1] Non [2] |
| 62 le coût des soins médicaux | NA [0] Oui [1] Non [2] |
| 63 le transport jusqu'à la clinique/hôpital | NA [0] Oui [1] Non [2] |
| 64 la peur d'être mis à la porte | NA [0] Oui [1] Non [2] |
| 65 les horaires d'ouverture de la clinique/hôpital | NA [0] Oui [1] Non [2] |
| 66 le personnel | NA [0] Oui [1] Non [2] |
| 67 votre permis de résidence | NA [0] Oui [1] Non [2] |
| 68 vous n'avez pas su où aller | NA [0] Oui [1] Non [2] |

69. Où recevez-vous actuellement de l'information par rapport aux soins médicaux?

69

| | |
|------------------------------------|-----|
| Hôpital/Clinique publique | [1] |
| Hôpital/Clinique privé(e) | [2] |
| Organisations Non Gouvernementales | [3] |
| Autre..... | [4] |

70. Où souhaiteriez-vous recevoir de l'information par rapport aux soins médicaux?

70

71. Quels sont les facteurs qui, selon vous, mettent en danger votre santé?

71-77

| | |
|--|-----------------|
| 71 De mauvaises conditions de travail | Oui [1] Non [2] |
| 72 De mauvaises conditions de logement | Oui [1] Non [2] |
| 73 Un manque d'information | Oui [1] Non [2] |
| 74 Les difficultés à expliquer le mal dont vous souffrez | Oui [1] Non [2] |
| 75 La pauvreté | Oui [1] Non [2] |
| 76 Le chômage | Oui [1] Non [2] |
| 77 Autre..... | Oui [1] Non [2] |

72. À qui vous adressez-vous lorsque vous êtes malade?

78-83

| | |
|---|-----------------|
| 78 Des amis de votre communauté | Oui [1] Non [2] |
| 79 Des amis vivant à Cape Town, en dehors de votre communauté | Oui [1] Non [2] |
| 80 Un pharmacien | Oui [1] Non [2] |
| 81 Un docteur | Oui [1] Non [2] |
| 82 Une organisation travaillant pour les réfugiés | Oui [1] Non [2] |
| 83 Personne | Oui [1] Non [2] |

TABLE 1.1

| Nationality | No | PROPORTION | % | M | PROPORTION | % | F | PROPORTION | % | p*q |
|----------------------|-------------|------------|------------|-------------|-------------|--------------|-------------|-------------|--------------|-----------------|
| ANGOLA | 1605 | 0.22 | 22.07 | 1428 | 0.20 | 19.63 | 177 | 0.02 | 2.43 | 1719.799 |
| BOTSWANA | 2 | 0.00 | 0.03 | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2.749141 |
| BURUNDI | 445 | 0.06 | 6.12 | 291 | 0.04 | 4.00 | 154 | 0.02 | 2.12 | 574.4158 |
| CAMEROON | 20 | 0.00 | 0.27 | 17 | 0.00 | 0.23 | 3 | 0.00 | 0.04 | 27.42335 |
| CONGO BRAZZAVILLE | 168 | 0.02 | 2.31 | 127 | 0.02 | 1.75 | 41 | 0.01 | 0.56 | 225.6556 |
| CENTRAL AFRICAN REP. | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.37 |
| CHINA | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| COMOROS | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| DRC | 3291 | 0.45 | 45.25 | 2216 | 0.30 | 30.47 | 1075 | 0.15 | 14.78 | 2477.433 |
| ETHIOPIA | 10 | 0.00 | 0.14 | 8 | 0.00 | 0.11 | 2 | 0.00 | 0.03 | 13.73058 |
| GHANA | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2 | 0.00 | 0.03 | 2.749141 |
| HAITI | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| IRAN | 5 | 0.00 | 0.07 | 3 | 0.00 | 0.04 | 2 | 0.00 | 0.03 | 6.870016 |
| IVORY COAST | 4 | 0.00 | 0.05 | 3 | 0.00 | 0.04 | 1 | 0.00 | 0.01 | 5.496769 |
| KENYA | 53 | 0.01 | 0.73 | 45 | 0.01 | 0.62 | 8 | 0.00 | 0.11 | 72.34123 |
| LIBERIA | 3 | 0.00 | 0.04 | 2 | 0.00 | 0.03 | 1 | 0.00 | 0.01 | 4.123144 |
| MALAWI | 14 | 0.00 | 0.19 | 13 | 0.00 | 0.18 | 1 | 0.00 | 0.01 | 19.21222 |
| MOZAMBIQUE | 13 | 0.00 | 0.18 | 10 | 0.00 | 0.14 | 3 | 0.00 | 0.04 | 17.84238 |
| NIGERIA | 4 | 0.00 | 0.05 | 3 | 0.00 | 0.04 | 1 | 0.00 | 0.01 | 5.496769 |
| RWANDA | 448 | 0.06 | 6.16 | 225 | 0.03 | 3.09 | 223 | 0.03 | 3.07 | 578.0341 |
| SAO TOME | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| SENEGAL | 2 | 0.00 | 0.03 | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2.749141 |
| SIERRA LEONE | 3 | 0.00 | 0.04 | 3 | 0.00 | 0.04 | 0 | 0.00 | 0.00 | 4.123144 |
| SOMALIA | 47 | 0.01 | 0.65 | 32 | 0.00 | 0.44 | 15 | 0.00 | 0.21 | 64.20497 |
| SUDAN | 16 | 0.00 | 0.22 | 16 | 0.00 | 0.22 | 0 | 0.00 | 0.00 | 21.95078 |
| TANZANIA | 803 | 0.11 | 11.04 | 795 | 0.11 | 10.93 | 8 | 0.00 | 0.11 | 982.1835 |
| UGANDA | 55 | 0.01 | 0.76 | 44 | 0.01 | 0.60 | 11 | 0.00 | 0.15 | 75.05029 |
| TOGO | 2 | 0.00 | 0.03 | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2.749141 |
| ZAMBIA | 13 | 0.00 | 0.18 | 8 | 0.00 | 0.11 | 5 | 0.00 | 0.07 | 17.84238 |
| ZANZIBAR | 81 | 0.01 | 1.11 | 80 | 0.01 | 1.10 | 1 | 0.00 | 0.01 | 110.1305 |
| ZIMBABWE | 159 | 0.02 | 2.19 | 103 | 0.01 | 1.42 | 56 | 0.01 | 0.77 | 213.8375 |
| TOT | 7273 | 1 | 100 | 5483 | 0.75 | 75.39 | 1790 | 0.25 | 24.61 | |

Calculation for Table 1.1

SAMPLE SIZE

381

Probability level = 95%

Confidence interval = 10%

Formula for Sample size: $n = (1-n/N) \cdot t^2 \cdot (p \cdot q) / d^2$

SAMPLE SIZE WITH ADJUSTAMENT $n' = n / (1 - [(n-1)/N])$

381

The calculation in this case are based on the broader sample frame with and without contact details, but the result of 381 will be applied to the final list in table 1.2 and 1.3

TABLE 1.2

| CHRISTIAN COUNTRIES | | | | | | | | | | | |
|---------------------|-------------|------------|---------------|-------------|-------------|-------------|-------------|------|------------|------------|------------|
| Nationality | No | PROPORTION | % | M | PROPORTION | F | PROPORTION | p*q | M | F | TOTAL |
| ANGOLA | 834 | 0.20 | 19.73 | 721 | 0.17 | 113 | 0.03 | 1583 | 64 | 10 | 74 |
| BOTSWANA | 2 | 0.00 | 0.05 | 2 | 0.00 | 0 | 0.00 | 5 | 0 | 0 | 0 |
| BURUNDI | 278 | 0.07 | 6.58 | 182 | 0.04 | 96 | 0.02 | 614 | 16 | 9 | 25 |
| CAMEROON | 15 | 0.00 | 0.35 | 12 | 0.00 | 3 | 0.00 | 35 | 1 | 0 | 1 |
| CHINA | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| COMOROS | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| CONGO BRAZZAVILLE | 152 | 0.04 | 3.60 | 114 | 0.03 | 38 | 0.01 | 347 | 10 | 3 | 13 |
| DRC | 2429 | 0.57 | 57.45 | 1665 | 0.39 | 764 | 0.18 | 2444 | 150 | 69 | 219 |
| GHANA | 1 | 0.00 | 0.02 | 0 | 0.00 | 1 | 0.00 | 2 | 0 | 0 | 0 |
| HAITI | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| KENYA | 34 | 0.01 | 0.80 | 28 | 0.01 | 6 | 0.00 | 80 | 3 | 1 | 4 |
| IRAN | 2 | 0.00 | 0.05 | 1 | 0.00 | 1 | 0.00 | 5 | 0 | 0 | 0 |
| MALAWI | 14 | 0.00 | 0.33 | 13 | 0.00 | 1 | 0.00 | 33 | 1 | 0 | 1 |
| MOZAMBIQUE | 11 | 0.00 | 0.26 | 8 | 0.00 | 3 | 0.00 | 26 | 1 | 0 | 1 |
| RWANDA | 268 | 0.06 | 6.34 | 128 | 0.03 | 140 | 0.03 | 594 | 12 | 13 | 25 |
| TOGO | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| UGANDA | 42 | 0.01 | 0.99 | 33 | 0.01 | 9 | 0.00 | 98 | 3 | 1 | 4 |
| ZAMBIA | 13 | 0.00 | 0.31 | 8 | 0.00 | 5 | 0.00 | 31 | 1 | 0 | 1 |
| ZIMBABWE | 129 | 0.03 | 3.05 | 87 | 0.02 | 42 | 0.01 | 296 | 8 | 4 | 12 |
| TOT | 4228 | 1 | 100.00 | 3006 | 0.71 | 1222 | 0.29 | | 270 | 110 | 381 |

TABLE 1.3

| MUSLIM COUNTRIES | | | | | | | | | | | |
|------------------|------------|-------------|---------------|------------|-------------|-----------|-------------|------|------------|-----------|------------|
| Nationality | No | PROPORTION | % | TOT M | PROPORTION | TOT F | PROPORTION | p*q | M | F | TOTAL |
| ETHIOPIA | 6 | 0.01 | 0.90 | 5 | 0.01 | 1 | 0.00 | 89 | 3 | 1 | 4 |
| IVORY COAST | 3 | 0.00 | 0.45 | 2 | 0.00 | 1 | 0.00 | 45 | 1 | 1 | 2 |
| LIBERIA | 3 | 0.00 | 0.45 | 2 | 0.00 | 1 | 0.00 | 45 | 1 | 1 | 2 |
| NIGERIA | 4 | 0.01 | 0.60 | 3 | 0.00 | 1 | 0.00 | 60 | 2 | 1 | 3 |
| SENEGAL | 1 | 0.00 | 0.15 | 1 | 0.00 | 0 | 0.00 | 15 | 1 | 0 | 1 |
| SIERRA LEONE | 1 | 0.00 | 0.15 | 1 | 0.00 | 0 | 0.00 | 15 | 1 | 0 | 1 |
| SOMALIA | 31 | 0.05 | 4.65 | 19 | 0.03 | 12 | 0.02 | 444 | 11 | 7 | 18 |
| SUDAN | 11 | 0.02 | 1.65 | 11 | 0.02 | 0 | 0.00 | 162 | 6 | 0 | 6 |
| TANZANIA | 567 | 0.85 | 85.14 | 554 | 0.83 | 13 | 0.02 | 1266 | 317 | 7 | 324 |
| ZANZIBAR | 39 | 0.06 | 5.86 | 38 | 0.06 | 1 | 0.00 | 551 | 22 | 1 | 23 |
| TOT | 666 | 1.00 | 100.00 | 636 | 0.95 | 30 | 0.05 | | 364 | 17 | 383 |

TABLE 1.4

| Nationality | No | PROPORTION | % | M | PROPORTION | % | F | PROPORTION | % | p*q |
|----------------------|-------------|------------|------------|-------------|-------------|--------------|-------------|-------------|--------------|-----------------|
| ANGOLA | 1605 | 0.22 | 22.07 | 1428 | 0.20 | 19.63 | 177 | 0.02 | 2.43 | 1719.799 |
| BOTSWANA | 2 | 0.00 | 0.03 | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2.749141 |
| BURUNDI | 445 | 0.06 | 6.12 | 291 | 0.04 | 4.00 | 154 | 0.02 | 2.12 | 574.4158 |
| CAMEROON | 20 | 0.00 | 0.27 | 17 | 0.00 | 0.23 | 3 | 0.00 | 0.04 | 27.42335 |
| CONGO BRAZZAVILLE | 168 | 0.02 | 2.31 | 127 | 0.02 | 1.75 | 41 | 0.01 | 0.56 | 225.6556 |
| CENTRAL AFRICAN REP. | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.37 |
| CHINA | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| COMOROS | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| DRC | 3291 | 0.45 | 45.25 | 2216 | 0.30 | 30.47 | 1075 | 0.15 | 14.78 | 2477.433 |
| ETHIOPIA | 10 | 0.00 | 0.14 | 8 | 0.00 | 0.11 | 2 | 0.00 | 0.03 | 13.73058 |
| GHANA | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2 | 0.00 | 0.03 | 2.749141 |
| HAITI | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| IRAN | 5 | 0.00 | 0.07 | 3 | 0.00 | 0.04 | 2 | 0.00 | 0.03 | 6.870016 |
| IVORY COAST | 4 | 0.00 | 0.05 | 3 | 0.00 | 0.04 | 1 | 0.00 | 0.01 | 5.496769 |
| KENYA | 53 | 0.01 | 0.73 | 45 | 0.01 | 0.62 | 8 | 0.00 | 0.11 | 72.34123 |
| LIBERIA | 3 | 0.00 | 0.04 | 2 | 0.00 | 0.03 | 1 | 0.00 | 0.01 | 4.123144 |
| MALAWI | 14 | 0.00 | 0.19 | 13 | 0.00 | 0.18 | 1 | 0.00 | 0.01 | 19.21222 |
| MOZAMBIQUE | 13 | 0.00 | 0.18 | 10 | 0.00 | 0.14 | 3 | 0.00 | 0.04 | 17.84238 |
| NIGERIA | 4 | 0.00 | 0.05 | 3 | 0.00 | 0.04 | 1 | 0.00 | 0.01 | 5.496769 |
| RWANDA | 448 | 0.06 | 6.16 | 225 | 0.03 | 3.09 | 223 | 0.03 | 3.07 | 578.0341 |
| SAO TOME | 1 | 0.00 | 0.01 | 1 | 0.00 | 0.01 | 0 | 0.00 | 0.00 | 1.374759 |
| SENEGAL | 2 | 0.00 | 0.03 | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2.749141 |
| SIERRA LEONE | 3 | 0.00 | 0.04 | 3 | 0.00 | 0.04 | 0 | 0.00 | 0.00 | 4.123144 |
| SOMALIA | 47 | 0.01 | 0.65 | 32 | 0.00 | 0.44 | 15 | 0.00 | 0.21 | 64.20497 |
| SUDAN | 16 | 0.00 | 0.22 | 16 | 0.00 | 0.22 | 0 | 0.00 | 0.00 | 21.95078 |
| TANZANIA | 803 | 0.11 | 11.04 | 795 | 0.11 | 10.93 | 8 | 0.00 | 0.11 | 982.1835 |
| UGANDA | 55 | 0.01 | 0.76 | 44 | 0.01 | 0.60 | 11 | 0.00 | 0.15 | 75.05029 |
| TOGO | 2 | 0.00 | 0.03 | 2 | 0.00 | 0.03 | 0 | 0.00 | 0.00 | 2.749141 |
| ZAMBIA | 13 | 0.00 | 0.18 | 8 | 0.00 | 0.11 | 5 | 0.00 | 0.07 | 17.84238 |
| ZANZIBAR | 81 | 0.01 | 1.11 | 80 | 0.01 | 1.10 | 1 | 0.00 | 0.01 | 110.1305 |
| ZIMBABWE | 159 | 0.02 | 2.19 | 103 | 0.01 | 1.42 | 56 | 0.01 | 0.77 | 213.8375 |
| TOT | 7273 | 1 | 100 | 5483 | 0.75 | 75.39 | 1790 | 0.25 | 24.61 | |

Calculation for table 1.4

SAMPLE SIZE

1523

SAMPLE SIZE WITH ADJUSTAMENT

1523

Probability level = 95%
Confidence Interval = 5%

Formula for sample size = $n = 1 - (n/N) * t^2 * (p * q) / d^2$

Formula for adjustment = $n' = n / 1 + [(n-1)/N]$

University of Cape Town

TABLE 1.5

| Nationality | No | PROPORTION | % | M | PROPORTION | F | PROPORTION | p*q | M | F | TOTAL |
|-------------------|-------------|------------|---------------|-------------|-------------|-------------|-------------|------|-------------|------------|-------------|
| ANGOLA | 834 | 0.17 | 17.04 | 721 | 0.15 | 113 | 0.02 | 1414 | 224 | 35 | 260 |
| BOTSWANA | 2 | 0.00 | 0.04 | 2 | 0.00 | 0 | 0.00 | 4 | 1 | 0 | 1 |
| BURUNDI | 278 | 0.06 | 5.68 | 182 | 0.04 | 96 | 0.02 | 536 | 57 | 30 | 87 |
| CAMEROON | 15 | 0.00 | 0.31 | 12 | 0.00 | 3 | 0.00 | 31 | 4 | 1 | 5 |
| CHINA | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| COMOROS | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| CONGO BRAZZAVILLE | 152 | 0.03 | 3.11 | 114 | 0.02 | 38 | 0.01 | 301 | 35 | 12 | 47 |
| DRC | 2429 | 0.50 | 49.63 | 1665 | 0.34 | 764 | 0.16 | 2500 | 518 | 238 | 756 |
| ETHIOPIA | 6 | 0.00 | 0.12 | 5 | 0.00 | 1 | 0.00 | 12 | 2 | 0 | 2 |
| GHANA | 1 | 0.00 | 0.02 | 0 | 0.00 | 1 | 0.00 | 2 | 0 | 0 | 0 |
| HAITI | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| KENYA | 34 | 0.01 | 0.69 | 28 | 0.01 | 6 | 0.00 | 69 | 9 | 2 | 11 |
| IRAN | 2 | 0.00 | 0.04 | 1 | 0.00 | 1 | 0.00 | 4 | 0 | 0 | 1 |
| IVORY COAST | 3 | 0.00 | 0.06 | 2 | 0.00 | 1 | 0.00 | 6 | 1 | 0 | 1 |
| LIBERIA | 3 | 0.00 | 0.06 | 2 | 0.00 | 1 | 0.00 | 6 | 1 | 0 | 1 |
| MALAWI | 14 | 0.00 | 0.29 | 13 | 0.00 | 1 | 0.00 | 29 | 4 | 0 | 4 |
| MOZAMBIQUE | 11 | 0.00 | 0.22 | 8 | 0.00 | 3 | 0.00 | 22 | 2 | 1 | 3 |
| NIGERIA | 4 | 0.00 | 0.08 | 3 | 0.00 | 1 | 0.00 | 8 | 1 | 0 | 1 |
| RWANDA | 268 | 0.05 | 5.48 | 128 | 0.03 | 140 | 0.03 | 518 | 40 | 44 | 84 |
| SENEGAL | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| SIERRA LEONE | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| SOMALIA | 31 | 0.01 | 0.63 | 19 | 0.00 | 12 | 0.00 | 63 | 6 | 4 | 10 |
| SUDAN | 11 | 0.00 | 0.22 | 11 | 0.00 | 0 | 0.00 | 22 | 3 | 0 | 3 |
| TANZANIA | 567 | 0.12 | 11.59 | 554 | 0.11 | 13 | 0.00 | 1024 | 172 | 4 | 176 |
| TOGO | 1 | 0.00 | 0.02 | 1 | 0.00 | 0 | 0.00 | 2 | 0 | 0 | 0 |
| UGANDA | 42 | 0.01 | 0.86 | 33 | 0.01 | 9 | 0.00 | 85 | 10 | 3 | 13 |
| ZAMBIA | 13 | 0.00 | 0.27 | 8 | 0.00 | 5 | 0.00 | 26 | 2 | 2 | 4 |
| ZANZIBAR | 39 | 0.01 | 0.80 | 38 | 0.01 | 1 | 0.00 | 79 | 12 | 0 | 12 |
| ZIMBABWE | 129 | 0.03 | 2.64 | 87 | 0.02 | 42 | 0.01 | 257 | 27 | 13 | 40 |
| TOT | 4894 | 1 | 100.00 | 3642 | 0.74 | 1252 | 0.26 | | 1133 | 390 | 1524 |