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Refugee HIV/AIDS program in Cape Town: Comparison with the UNAIDS
Best Practice Guidelines (BPGS).

By: Alice Whitehead Mafuleka

Student Number: MFLALI001

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Department of Politics

University of Cape Town

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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.

Every idea from the work or works of other people has been attributed, and has been cited and referenced.

Signature

Date

Supervisor:

University of Cape Town

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ABSTRACT

In 2004, the United Nations High Commissioner for Refugees (UNHCR) issued a report on refugee health rights violations at health centres in South Africa, raising questions about the nature of refugee HIV/AIDS programs in the country. Further research on the existing programs in Cape Town has also revealed that little or no information is available on the practices that form part of these HIV/AIDS initiatives. Apart from a total lack of information on HIV/AIDS prevalence rates amongst refugees, these programs were also not in line with global best practices.

This study seeks to overcome this lack of information by documenting the practices of HIV/AIDS programs for refugees in Cape Town and comparing those practices to UNAIDS Best Practice Guidelines (BPGS) for migrants. Primary and secondary data were collected from program leaders in the prevention program and also in the treatment program. There is only one prevention organisation namely the Planned Parenthood Association of Southern Africa (PPASA); and the treatment program is in all public hospitals that are administering Anti retroviral therapy (ART). While the PPASA was the only organisation that could represent the prevention category and thus was included as a case study, the choice of the hospital centre was based on the availability of an interpreter for refugees to communicate with the hospital staff. Victoria Hospital was the only centre in Cape Town without a French interpreter and thus was chosen from the list of health centres in Cape Town and thus would provide a good case consistent with the reports from the UNHCR.

The data findings from one program manager at PPASA were complemented by program documents, and from three health staff members at the hospital. When viewed as individual cases, there were no contradictions in the data findings from all the sources, which validated the use of a table to read the trends.

The study found that the prevention category of the national HIV/AIDS response plan is well funded and supported by both government and the UNHCR and its programs have both the consolidation and strategic orientation consistent with the UNAIDS BPGS. However, the treatment category at Victoria Hospital falls short of the UNAIDS BPGS standards at all levels. There is also at Victoria Hospital, no system available for collecting epidemiological surveillance data for refugees that could be used to manage their healthcare needs.

This study concludes that much more effort needs to be put into care and support interventions for refugees affected by HIV/AIDS. The study also concludes that, in the case of Cape Town, channelling all the funds into one organisation which is the PPASA, with one target category specialising in prevention has resulted in some categories being more targeted than others. This has meant that some categories such as the care and support category have not received sufficient funding. The study recommends that the UNHCR identifies and provides funding to other specialist bodies in the care and support group, such as Catholic Welfare and Development (CWD), to help consolidate programs for refugees in that category in Cape Town.

The study further recommends that the HIV/AIDS national response plan must identify the steps needed to achieve goals that are specific to the health care needs of refugees. These strategic steps will set a precedent for the inclusion of linguistically and culturally appropriate approaches, the formation of health partnerships and the participation of refugees. Setting strategic goals would furthermore ensure that a budget will be set aside for these activities.

Finally, this study also recommends that both the government and the UNHCR find a way of collecting surveillance data for this population group to enable effective management of the disease.

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti Retroviral
ART	Anti Retroviral Therapy
BPG	Best Practice Guidelines
CSO	Civil Society Organisations
CSVR	Centre for the Study of Violence and Reconciliation
HIV	Human Immunodeficiency Virus
IOM	International Organisation for Migrants
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
OAU	Organization of African Unity
PPASA	Planned Parenthood Association of Southern Africa
SAMP	Southern Africa Migration Program
UN	United Nations
UNAIDS	United Nations AIDS (Joint United Nations Programme on HIV/AIDS)
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

CHAPTER ONE

Introduction

The relationship between the HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) pandemic and migration was recognized by the United Nations' General Assembly Special Session on HIV/AIDS in June 2001 (UNAIDS 2001). One of the recommendations from that session was that countries should begin to develop and implement national, regional and international strategies to facilitate access to HIV/AIDS programs for migrants and mobile workers.

Refugees have been described as some of the most vulnerable to HIV/AIDS (Bayard 2004). In their destination countries, refugees are very often faced with poverty, discrimination, exploitation and limited access to social, educational and health services. These factors can inhibit their exposure to information and also increase the rate of prostitution (Bayard 2004). Refugees also experience separation from their families and partners, and from the socio-cultural norms that guide behaviour in stable communities. These conditions not only put refugees on an unequal footing with host populations in accessing HIV/AIDS services, but also enhance their vulnerability to contracting HIV/AIDS.

South Africa officially hosts around 117,500 refugees and asylum seekers, but the extent of their HIV/AIDS disease burden is not known (UNHCR 2005). However, the UNHCR estimated in 2004 that there were large numbers of male urban refugees with HIV/AIDS (Robinson 2004). Their vulnerability to infection, can, however be predicted from their exposure to mixing of populations of differing prevalence rates and access to HIV/AIDS services. Research shows that mobility leads to mixing of populations of differing prevalence rates which enhances vulnerability to HIV/AIDS (Mock et al 2004). In South Africa, close to 50% of refugees interact on a social level with the host community and with foreigners from other parts of the world (Abrahams & Hajiannis 2001). Most of these refugees come from the Southern Central African countries, a region with high levels of HIV infection, with about 25 million people being infected. The infection rates of the refugees' countries of origin vary between 5% for Burundi and 28% for Zimbabwe (Abrahams & Hajiannis 2001), while infection rates in South Africa are around 10%.

Moreover, 7.5 million of infected individuals in Southern Central Africa are adults between 15 and 45 years of age (UNAIDS 2004). Global trends show that most refugees fall within this age range, as migration peaks in the early 30s and drops off among the older age groups (Crush 2002). The age ranges amongst refugees in South Africa are synonymous with the

global trends seen in recent studies in Johannesburg, which have shown that only 5% of the migrant population in that city are over 45 years old (Abrahams & Hajiyiannis 2001).

Another factor affecting vulnerability is the types of refugee settlement in host countries. Well-organized refugee camps offer improved protection, nutrition, health services (including HIV/AIDS prevention, treatment of opportunistic infections and care), education and social services (Abrahams & Hajiyiannis 2001). However, in situations where refugees are dispersed, the risks of contracting HIV/AIDS appear to be much higher, because the protective factors that exist in refugee camps are removed, and because people generally find themselves in environments of higher HIV/AIDS prevalence (Bayard 2004). These settlement patterns may indeed be used to estimate the levels of vulnerability among those refugees in South Africa who are not in camps, but more or less integrated into the local communities (Crush 2003). These refugees are self-supporting, live in urban regions and are widely dispersed (Pillai & Polzer 2003). As such, they do not benefit from any protective factors that would be characteristic of refugees in camps.

In South Africa however, the delivery of refugee HIV/AIDS service is the responsibility of the government. The refugee HIV/AIDS policy process in South Africa is robust and encompasses a large network of stakeholders including the department of health, the UNHCR through Planned Parenthood Association of Southern Africa (PPASA), the Red Cross and faith-based organisations. The refugees do not only have their HIV/AIDS needs incorporated into the South African National HIV/AIDS Response Plan, but also enjoy free access to public healthcare at hospitals, while the partnering civil organisations assists with implementing the prevention, care and support categories. The department of health runs ARV programs at hospitals, and facilitates for the adherence to legislation that allows all refugees with I.D to access HIV/AIDS services at hospitals, while the UNHCR has the role of exposing the various partners of the South African HIV/AIDS program to the global best practice approaches, and facilitating their integration.

In view of the above, this research sets out to document the delivery of the comprehensive HIV/AIDS programs for refugees, comparing them with the UNAIDS Best Practice Guidelines (BPGS). Furthermore, by examining the nature of public policy with regards to refugee HIV/AIDS policy, it will examine why programs in Cape Town may not be in line with the UNAIDS BPGS.

Definition and Operationalization of Concepts

Program: This can be defined as a group of projects working together towards a goal (McNamara 1998). In its most general use, a program is a collection of organizational resources that are geared to accomplishing a certain major goal or set of goals (McNamara 1998).

A program in this research refers to the two types of initiatives that exist around HIV/AIDS for refugees. One such initiative is the treatment program at public hospitals where refugees can access free HIV/AIDS related medication; and the other is the prevention initiative run by PPASA, which is specifically targeted at refugees. In both instances, the programs are a collection of organisational resources with varied objectives geared towards offering a comprehensive response to HIV/AIDS for refugees.

Refugee: The Organization of African Unity (OAU) definition of a refugee is one that is extended from the United Nations (UN) 1951 definition:

Refugees are individuals forced to leave a country because of persecution deliberately targeted at them or the group to which they belong, or because war or civil conflicts have made it physically unsafe or otherwise impossible to remain at home (UNHCHR 2001).

This definitions' focus is only limited to conflict refugees, and does not include other types of forced migrants who would also qualify for refugee status. Refugees in South Africa represent, in some respects, tendencies defined under the OAU, where refugees from Congo DR, Burundi, Rwanda and Somalia are victims of conflict; but in other respects, different type of refugees are represented, such as, for example, economic refugees escaping poverty and not necessarily physical harm (for example, Zimbabweans). This research will thus include economic refugees, because they are just as socially disadvantaged as refugees affected by conflict, with regard to their vulnerability to HIV/AIDS.

BPGS: Best Practice Guidelines are defined as a set of procedures, which have been identified as the best way to treat a particular problem, and which can be replicated in any situation or setting (Sinard & Rice 2001). Best practices are not authoritative, nor do they represent the regulations that must be followed, but they are merely a collection of evidence of best practices that have worked elsewhere. The UNAIDS BPGS for migrants are a collection of evidence-based principles that have worked well so far in other places and can be replicated. The principles are a

combination of responses at program level and at policy level that need to be integrated to be effective.

Public Policy

Public policy encompasses the two functions of government: the expressions of the states' will either verbally, or through a statement of intent, and the execution of that will through public administration (Friedrich 1999). The states' will and execution is shaped by networks of stakeholders that push through their interests. Therefore public policy process is inclusive of networks of stakeholders. In this research, policy is viewed as a continuous cyclical process between formulation and adjustment of the states will, and the process of execution. Thus the public policy statement and its administration are understood as overlapping jurisdictions, whereby there is continued feedback and adjustments to both the policy statements and style of administering.

Public Administration

Public administration is defined as the management of public programs. It is the administrative side of government, with the duty to manage resources to achieve objectives of public policy (Coetzee 1988). Therefore public administration is the vehicle through which public services are executed. In this research, the term public administration will also be used to refer to implementation, and will include the study of how the refugee HIV/AIDS networks turn policy into programs that deliver public service. The function of the policy network will be analysed in terms of how they share and allocate other resources for the refugee HIV/AIDS program, and how they share and coordinate themselves for public service delivery.

Public Service

Public services are those services provided by governments for their citizens. These services can be executed either through the public sector or by outsourcing to the private sector. Public service also includes those who work in the public sector (Perry & Wise 1990). In this research, public service will refer to the HIV/AIDS public health service provided for refugees, and all the role

players in its delivery. At this level, the research will target the nature of services offered, and the roles of key members of staff such as the hospital staff and the PPASA management.

Problem Statement

International law guarantees refugees global rights to healthcare through the unilateral declaration of human rights (UNHCHR 1948-1998). Within these rights, every refugee has the right to public healthcare of the same standard as the host populations. Host countries are thus required to draft laws and policies that are inclusive of this right. Consequently, the South African Constitution guarantees refugees the right to healthcare of equal standard as the citizens themselves (GOV 1998). Thus refugees in South Africa have been included in both the National Health Policy and in the National HIV/AIDS Strategic Plan, 2000-2005 (GOV 2000). In addition health services are free for refugees and asylum seekers with valid legal identity documents at public hospitals throughout South Africa.

However, in South Africa, the inclusion of refugees in the national policy has not yielded results that are consistent with the UNAIDS BPGS for migrants. Freedom of access of healthcare for instance has not meant ease of access for refugees. In 2004, for example, problems were reported in implementation of this policy, where the use of refugee identity cards at hospitals was not recognised as sufficient to guarantee healthcare (Robinson 2004). The UNHCR also reported that refugees' access to healthcare was inhibited by language barriers at these hospitals. This is because most refugees in South Africa speak other languages better than English, or any of the other eleven official languages. The hospitals do not always have as part of their staff, interpreters that are familiar with refugees' languages, sometimes resulting in delayed or even denied treatment (Robinson 2004).

A separate UNHCR review report on South Africa concluded that HIV/AIDS programs were not targeted at refugees (Crush 2003). The policy factors considered in this review included evidence of recognition of refugee language barriers in the design of national prevention campaigns, such as condom distributions. These campaigns were found to not be targeted sufficiently at refugees. In yet another research review, results showed that there were no linguistically appropriate prevention materials for refugees (EQUINET 2003). The evidences of standards that do not conform to the best practices at public hospitals as reported in the media and results of the UNHCR review are the basis of this research as the raise questions around the nature

of refugee HIV/AIDS programs and services in South Africa. Thus this research is developed against this background of problems and has the intention to understand not only the causes of these problems within a policy context, but also the extent to which comparison can be drawn to the UNAIDS BPGS for such instances.

1.4 Research Question

1.4.1 Key Research Questions

The key research questions are:

What HIV/AIDS programs for refugees exist in Cape Town, and how do these programs compare to the UNAIDS best practice guidelines for migrants? Furthermore, why do the managers of these programs not follow the UNAIDS best practices?

1.4.2 Research Sub Questions

The following are some of the questions that this research will attempt to answer:

- 1) What are the policies currently being used in the refugee HIV/AIDS initiatives?
- 2) Are the healthcare practitioners aware of the UNAIDS best practice guidelines?
- 3) What are the resources and capacity levels in the participating programs and public hospitals, and are they adequate to implement HIV/AIDS programs for refugees that adhere to the UNAIDS BPGS?

1.5 Research Objective

Consequently, the objective of this study is to explore and document the HIV/AIDS programs for refugees, operating in Cape Town. This documentation will describe the existing programs, and will compare them to best practice guidelines.

1.6 Contribution to Knowledge

The case of refugees' health and HIV/AIDS in South Africa cannot be looked at in isolation from international best practice approaches. The UNAIDS is one of the global organisations

documenting global best practice guidelines. The UNAIDS BPGS for migrants, like many BPGS have been tried and adopted in some instances, and rejected in others. There are many theories to explain the dynamics around the adoption or non-adoption of BPGS. This research will thus seek to contribute to this debate around the concepts of best practice guidelines and also to theories of migration and HIV/AIDS.

1.7 Motivation for Research

Reviews from the European HIV/AIDS initiatives for refugees and reports from the UNHCR on African refugees' HIV/AIDS programs show consistency in the type of problem areas encountered in both design and implementation. The BPGS are used in many countries around the world and have the objective of informing programs on how best to design and implement programs. As yet, however, there is no documentation on the practice of HIV/AIDS programs and refugees in Cape Town or how it compares to the BPGS.

Fig 1. Motivation of the research

The research is motivated by the need to:

1. Document the practices of implementing the refugee HIV/AIDS programs
2. Compare those practices to UNAIDS BPGS
3. Understand those factors that inhibit programs from adopting the UNAIDS best practices for migrants

There is currently no research on HIV/AIDS surveillance data pertaining to refugees in South Africa, nor is there any research on the extent to which refugees in fact access healthcare, nor on refugee HIV/AIDS practices being used in Cape Town. By describing what is currently being done and assessing how this compares to best practices, this research will be one of the first studies to provide a basis for valuable research discussions around HIV/AIDS and refugees.

1.8 Research Methodology

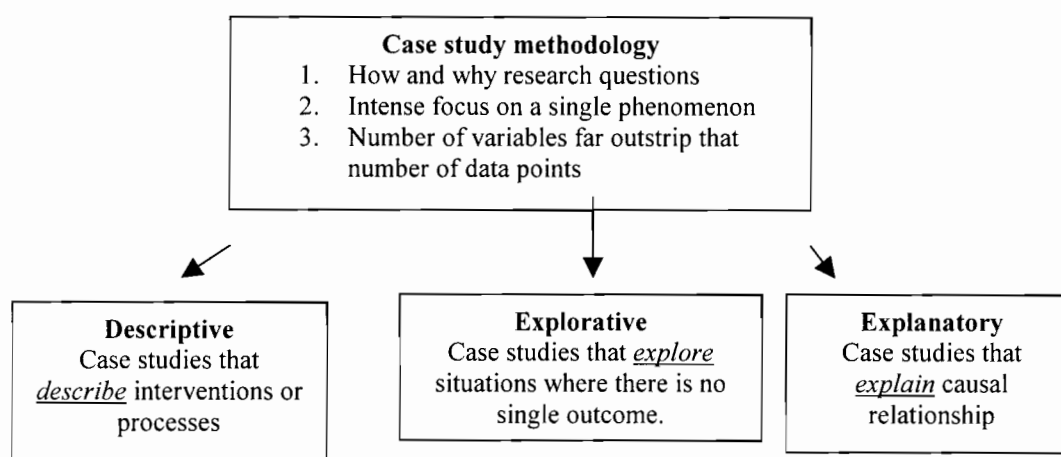
This research adopted a case study methodology. A case study is a method of learning about a complex subject, based on a comprehensive understanding of that subject obtained by extensive description and analysis of the instance, taken as a whole and in its context (Davey 1991).

In this research, the case study investigated how the HIV/AIDS initiative for refugees in Cape Town is organised and implemented. There are two types of HIV/AIDS programs in Cape Town and these are the prevention and the treatment programs. The treatment initiative takes place at all public hospitals that offer ART to the general public while the prevention initiative is implemented by the Non governmental organisation namely the PPASA. In this research, the Victoria State Hospital was chosen as a case study for the treatment program and the PPASA was the case study for prevention program. Thus two case studies were conducted, described and analysed in their contexts as whole separate refugee HIV/AIDS initiatives.

A further reason for using a case study methodology is that the two types of refugee HIV/AIDS programs in Cape Town are isolated and independent of each other. The structural and capacity dynamics in the programs mentioned above are funded differently, with different resource bases and levels of focus on refugees. In choosing the programs to include in the case studies, the rationale was that one program from the prevention category and one from the treatment category would be included. While the PPASA is the only organization in Cape Town with a prevention focus on refugees and therefore the only inclusion in the research from that category, the Victoria hospital was the only public hospital from the treatment category at the time that did not have a refugee specific interpreter and therefore was included in the research. The non availability of an interpreter at Victoria hospital was a key indicator of the non adherence to the UNAIDS BPGS and also a key problem as referred to in the problem statement and therefore including Victoria hospital would help answering the research questions.

1.8.1 Type of case study

In general, speaking, there are three types of case studies: descriptive, exploratory and explanatory, as summarised in Figure 2 below (Ziviani & Fisher 2004):

Figure 2 Types of case studies

This research adopted the descriptive method. A descriptive case study describes in detail the subject being studied. In the context of this particular study, then, it describes the refugees HIV/AIDS programs in Cape Town and the dynamics that affect how these programs compare to and deviate from the best practice guidelines set out by the UNAIDS organisation.

1.8.2 Target population sample

The research was conducted in Cape Town. PPASA is the only NGO that provides prevention services which are targeted at refugees, and it was therefore the obvious choice to include in the study. There are several public hospitals in Western Cape with refugees on treatment programs. The particular hospital that was chosen for the purposes of this research was selected precisely because it deviated from the UNAIDS BPGS: Victoria Hospital has no interpreters for refugees. This deviation made Victoria a special case and relevant to address the problem statement and research question of this study.

1.8.3 Case study design

This case study uses a multiple case design, which involves the collection and analysis of data from two or more sources of information. This research thus looks at the two selected HIV/AIDS programs. This case study will furthermore use only one stage of analysis, which means that each HIV/AIDS program will be treated as a comprehensive unit and data will be analysed within the context of that case.

1.8.3.1 Data and information collection

Data was derived from documentation, archival records and interviews at the two sites, namely PPASA and Victoria Hospital. A review of the supporting documentation for each program, including internal and external reports on the program documents, was conducted. The South African National HIV/AIDS Strategy was reviewed to study how its content and implementation affect the extent to which the UNAIDS BPGS can be met. Other documents reviewed with the purpose of providing a framework for benchmarking, were the UNHCR guidelines on refugees, the UNAIDS guidelines on HIV/AIDS on migration, and the national strategy of the South African government on HIV/AIDS.

1.8.3.2 Interviews

Semi-structured guided interviews were used to interact with key acting health personnel at the Victoria Hospital and at PPASA. A semi-structured interview consists of a set of themes to be investigated in each unit of analysis, but allows for flexibility in the nature of questioning. In this case study, certain common themes were investigated at both the hospital and PPASA. A questionnaire presenting the selected themes was therefore used in the various interviews. The main target interviewees were the program managers and support staff involved in these programs. These interviews were conducted in person during visits to the program centers. Where the key people were not available during the visits, follow-up interviews were completed by telephone or email.

1.8.4 Data analysis

There are two main methods of analyzing data and these are pattern matching and explanation building. While explanation building involves the building of theory as the research progresses, pattern matching involves the use of already developed and existing theory to compare and match with research findings (GOA 1990). In this research, the objective is to compare the already existing theories with the research findings. The UNAIDS BPGS already exist as a comparable, acceptable and expected standard. Thus the use of pattern matching as a method of analysis is more appropriate in comparing the research findings with the already existing UNAIDS BPGS. Pattern matching will also be used to provide explanations to why the Cape Town based HIV/AIDS programs for refugees may deviate from the UNAIDS PBGS.

1.8.5 Scope and limitations of the study

This case study is limited by the lack of consolidated documentation of HIV/AIDS prevalence rates among refugees in Cape Town. The many organisations working with refugees in South Africa are only just beginning to consolidate information in that area. Even the UNHCR has no consolidated information available on the HIV/AIDS situation of refugees in this country.

In the field of public health, public hospitals are the main sources of data regarding the prevalence rates for host populations. In the case of refugees, however, information on identity cards is collected, and a database is kept on all patients receiving medical care. However, these data do not reflect the national status of the holder, which makes it hard to identify prevalence rates among refugees and the extent to which these hospitals are utilized by them. Even those refugees on Anti Retrovirals (ARVs) are not listed in such a way that they can be identified as refugees. This further hampers any opportunities for identifying trends.

1.8.6 Reporting style

The structure of this dissertation thus consists of an introduction, a methodology, a literature review, a presentation of the results and a discussion and analysis of the findings. Chapter one introduces the research concept and question and the methodology, while chapter two presents the literature review and theoretical context and the background to the research question is set. Chapter three places the research in the public policy context and Chapter four describes the field study and collection of data and discusses the findings thereof while the last Chapter concludes the study and also presents recommendations for further research. The next chapter is a discussion of the literature review which is inclusive of the relevant background and other supporting research that shape the research in question.

CHAPTER TWO

2.1 Theoretical Background and Literature Review

The UNAIDS BPGS are set against a background of human rights and HIV/AIDS. This means that the upholding of human rights informs the basis of policy and program design for migrants. The history of rights and HIV/AIDS is furthermore embedded within health rights, as recommended by the Declaration of Human Rights in (UNHCHR 1948).

The Commission on Human Rights and the Joint United Nations Program on HIV/AIDS (UNAIDS) first issued their HIV/AIDS rights guidelines in 1996 (UNHCHR 1996). This was a result of debates and consultations over many years and from different angles of human health and of HIV/AIDS as defined by UNAIDS. Writers such as Gruskin and Tarantola have been instrumental in interpreting the role of human rights in relation to the HIV/AIDS epidemic. These writers propose that human rights are a practical form of protection for people infected with HIV, who may experience violations of their rights, particularly when governments ignore the obvious discrimination and stigmatisation of those with HIV/AIDS. Governments have a duty to enable the extension of rights to these people by providing the necessary enabling environments through their policies (Guskin & Tarantola 2001). Guskin and Tarantola introduce the role of rights and equity in policy design, which is relevant to understanding the position of refugees in host populations.

Authors on forced migration and HIV/AIDS, such as Bayard (2004) and Mock et al (2003), recognise the unique position of refugees in the light of HIV/AIDS. They view refugees as a particularly vulnerable group, because of the nature of forced migration, where people are displaced regardless of whether they are willing to move or not, live amongst host communities that have to provide for them purely out of obligation. War, poverty, famine or other hostile conditions in their countries of origin, a lack of preparedness to move, hostile policies in their host countries and socio-cultural shocks, as well as many other factors, create social, economic and legal disparities for refugees that place them at a disadvantage in their new situation. These disparities further enhance the level of vulnerability of refugees to HIV/AIDS.

Bayard (2004), who writes on the enhancing effects of forced migration on the risks and increased vulnerability to HIV/AIDS faced by refugees, uses theories of social movement and communicable diseases to analyse the causes and effects of conflict, mobility, mixing of

populations of differing prevalence rates and the spread of HIV/AIDS in refugees' destination countries (Bayard 2004). Theories of culture further help understand the enhanced HIV/AIDS vulnerability experienced by refugees because of their mobility. They experience cultural shocks, discontinuity and distortion of cultural beliefs all of which increase their vulnerability to communicable diseases. Thus there is consequently an argument for refugee programs that are culturally and linguistically appropriate (UNAIDS 2000).

Policies designed for the host population yield inequitable results for refugees. Consequently, a rights and equity-based approach to the design and implementation of the host country's policies and programs is needed to yield equitable outputs for the refugee population (Bayard 2004). The implementing partners in the field of migration and HIV/AIDS have based their design and implementation of programs on the two principles of human rights and equity. For instance, in their role of drafting programs for migrants, the International Organization for Migrants (IOM) uses the rights framework for policy design and implementation that is comprehensive and applicable across borders and along the migrants' travel routes. This framework would be useful in designing programs for refugees, as the latter tend to be quite mobile within their communities and from town to town and may benefit from knowing what services are available to them and where to access them (IOM 2002).

The UN, similarly, has used the rights and equity approach to recommend that the social aspects of refugees be considered when designing policies and programs on the HIV/AIDS/STDS status of prevalence rates among migrants. These policies should also reflect current knowledge of the efficacy, feasibility and cost of interventions based on prevalence rates (IOM 2002). This is partly possible when there is good data on prevalence rates; the design of policies for any population group depends on it. In the collection of cardinal prevalence data, applying equity and rights principles leads to the recognition of the difference between refugees and host populations. The UN recommends that additional information collected on refugees away from home, such as mortality, nutrition or household goods, be compared with the country of origin (UNFPA 1995). Other studies recommend that emphasis be placed on differences that may exist between host populations and the newcomers in such fields as demographics, HIV/AIDS/STD incidence levels, incidences and types of risky behaviours, cultural sexual practices and also legal status of refugees, type of permit and duration of stay (UNFPA 1995). Such surveillance information gives a situation analysis of the pandemic and measures levels of vulnerability amongst refugees.

The UNAIDS BPGS model offers a rights and evidence-based guideline on approaches to the design and implementation of the HIV/AIDS policies and programs for migrants in general. As indicated above, these guidelines are based on the human rights concept as promoted by Guskin, Mann and Tarantola and other rights writers (Gruskin & Tarantola 2001). The UNAIDS recognises that the need to identify and widely disseminate best practices from all types of settings is a key priority of their function. The UNAIDS BPGS materials have been known to perform an important and useful role not served by other materials. They are valued by many because they are seen as authoritative (Funnell 1999). Sources of these UNAIDS best practice guidelines are wide-ranging, and include the UN system staff, NGOs, government representatives and agencies, community groups, and individuals. Other supporting guidelines that are especially targeted at refugees are the following (UNAIDS):

- ***Guidelines for HIV interventions in emergency settings***, which are suitable for government, NGO and United Nations agencies that are implementing HIV care and prevention programs in emergencies.
- ***Migrants HIV Testing and Counselling Guidelines***, which are targeted at counsellors working in emergency settings.
- ***Refugees and AIDS***, which is a booklet from the UNAIDS Best Practices collection, and summarises the issues, challenges and solutions.
- ***Reproductive Health in Refugee Situations***, which offers guidance to field staff in introducing and implementing reproductive health services in the refugee situation.

2.2 Literature Review

2.2.1 Forced Migration, HIV/AIDS Vulnerability and Public Policy

Mobility has been pivotal in the spread of HIV/AIDS. In many countries, HIV was first visible in the early stages of the epidemic along truck routes, in trading towns, and in border areas where populations are highly mobile (IOM 2004). Mobility itself has been identified as a risk factor for HIV infection, as data suggests that HIV spreads along migration routes (IOM 2004). In the Far East, for example, HIV prevalence was particularly high at the border crossing points and along transport routes in mainland Southeast Asia (Cambodia, Laos, Malaysia, Myanmar [Burma], Thailand, Vietnam, and southern China), and in Africa, similarly, along the heavily travelled

corridor in West Africa between Abidjan, Côte d'Ivoire, and Ouagadougou, Burkina Faso (Radebe 2003). In South Africa, the high HIV/AIDS rate has been attributed in part to its history of male labour migration (USAID 2001). With regard to refugees, however, their vulnerability to HIV/AIDS has been mainly influenced by conflict and forced movement.

Conflict itself has been linked to increased HIV/AIDS infection rates because of its range of impacts on health systems: it reduces capacity to screen blood and blood products; it reduces testing and treatment for HIV/AIDS and other sexually transmitted infections (STIS); it leads to the use of non-sterile medical equipment; and it halts HIV/AIDS prevention programs (Bayard 2004). Moreover, destroyed public health systems and infrastructure and increased population mobility have led to increased risk and vulnerability, as well as to increased exposure to and infection by HIV/AIDS (UNAIDS 2001).

Further research has revealed a direct correlation between the increase in the number of HIV infections in sub-Saharan Africa and hostility towards refugees – bearing in mind that of the 17 countries with the highest HIV/AIDS rates, 13 of them are in conflict zones (Radebe 2003). Conflict is likely to lead to increased movement, which in turn leads to population mixing. Population mobility furthermore leads to populations of differing prevalence rates; this is instrumental in enhancing vulnerability to HIV/AIDS. In Kenya, for example, the UNHCR associates the poor health of refugees who have the disease with the influence of nearby communities that have higher prevalence rates.

Other data from Rwanda provide some evidence that mixing populations with different HIV prevalence rates increases HIV prevalence overall (Mock et al 2004). A 1997 survey found an 11% HIV prevalence rate in both rural and urban areas. This contrasts with pre-war levels, which were low in rural areas (estimated at 1%), where approximately 95% of the population resided, and high in urban areas (over 10% of women attending antenatal clinics). Following displacement and return, HIV/AIDS infection among those who had lived in refugee camps in Tanzania or Zaire and then returned was 8.5%, representing a six to eight fold increase over the rates in the rural areas from which they came. The increase was even greater for those who had been internally displaced and who remained in Rwanda during the years of conflict (Bayard 2004).

Alternatively, conflict can also lead to reduced mobility due to damaged infrastructure, which may explain a reduction in infection rates in other cases. As a result, HIV prevalence rates in some areas of conflict appear lower than in more stable neighbouring areas. For instance, a

study in a rural community in Uganda found that the HIV infection rate for those who had migrated was 11.5%, twice that of those who had stayed behind (Mock et al 2003).

When comparing prevalence rates between refugees and host populations, the HIV/AIDS infection rates amongst refugees seem to be lower than in their host communities, which is contrary to myths that refugees are a source of the disease (Bayard 2004). The UNHCR measured HIV prevalence among pregnant women in more than 20 camps accommodating about 800,000 refugees in Kenya, Rwanda, Sudan and Tanzania. In three out of the four countries examined, there was a significantly lower HIV prevalence rate in camps than in the surrounding host communities. In northern Kenya, for example, the HIV rate among refugees was 5%, compared with 18% in the local population (Radebe 2003).

Several theories and concepts explain relationships between HIV/AIDS and conflict. One of these is the “Social Ecological Framework of HIV/AIDS and Conflict”. In terms of this framework, vulnerability is enhanced by the following seven factors:

1. Extended conflict, which may lead to cumulative impoverishment and poverty due to a loss of property and the destruction of livelihoods during wars that can lead to high levels of commercial sex as a coping strategy (Mock et al 2004).
2. Prolonged wars can also lead to breakdowns of social infrastructure: such breakdowns of health, education, transportation, and communications infrastructure can lead to decreased knowledge of HIV/AIDS, as well as to a lack of access to means of prevention of HIV transmission. A damaged infrastructure can also lead to extended isolation from modern communications, causing information separation regarding the epidemiology and prevention of the disease, which may further enhance vulnerability to the disease (UNAIDS 2001).
3. The increase in vulnerability to HIV/AIDS is also caused by the presence of army personnel amongst civilian populations. In conflict settings, there can be high degrees of sexual violence towards civil populations by an army with high sero-prevalence. In addition, the presence of army camps during conflict leads to commercial sexual activity and other commercial activities, partly because military personnel tend to be better remunerated than the surrounding communities (McGinn 2001). Moreover, the military are themselves particularly vulnerable to the disease and thereby instrumental in spreading it, because military service requires long periods away from home and family, and because

the military culture is one that values risk-taking. Most military personnel are themselves young men at the highest risk of contracting the HIV virus (Nguyen & Stovel 2004).

4. Vulnerability in conflict settings can be increased by the migration of people seeking safer areas. These movements increase population mixing of differing HIV/AIDS prevalence rates among the population, as people are exposed to different exposure levels, which may be lower or higher (Mock et al 2004). When movement becomes fluid because of dislocated populations moving back and forth between higher and lower risk areas, this mixing is further increased. War has also been known to increase partner exchange, as relationships generally tend to be more short-term, thereby further increasing the spread of the disease (Nguyen & Stovel 2004).

However, chronic conflict may also result in lower exposure opportunities, as social mixing can be reduced by isolation and limited population mobility following a damaged infrastructure and an increased risk of movement. The result of reduced mobility due to conflict may explain a case such as Angola, where mobility was limited and most of the population was concentrated in small islands of relative safety around provincial capitals (Bayard 2004).

5. Vulnerability to HIV/AIDS is increased by a complete absence of or reduced access to health services, resulting from the destruction of the health infrastructure (including personnel and physical infrastructure) during wars (UNAIDS 2001). In conflict situations, civilians also avoid using health facilities, as people may be afraid of imminent eruptions of violence, or they may distrust providers. Fear, mistrust or an absence of healthcare can also force people in conflict settings to become more reliant on self-care or traditional health systems (Mock et al 2003).

An issue that is related to accessibility to public healthcare is the inability of destroyed public health sectors to provide the surveillance function, the absence of which may delay recognition of diseases, including HIV/AIDS (UNAIDS 2001). Surveillance is a fundamental role of public health, and ensures the efficient and effective allocation of resources, the design, implementation, and evaluation of health services. In most of Southern Africa, the public health service is already under-resourced and seriously incapacitated, with a poor infrastructure. Conflict further weakens any existing public service efforts.

6. Vulnerability to HIV/AIDS is further enhanced by increased levels of malnutrition resulting from restricted production and access to food, which is common in situations of forced migration (Spiegel 2004).
7. Finally, vulnerability is enhanced by broken family structures and a loss of family, which is a common feature of wars. Populations affected by conflict typically have higher rates of child-headed households (e.g. orphans) and higher dependency ratios because of a greater numbers of female-headed households. In some cases, there will be higher levels of handicapped people and fewer able-bodied men, which can also increase levels of economically remunerative sexual activities (Bayard 2004).

The social ecology framework further explains the factors that lead to continued vulnerability to HIV/AIDS in the new host countries. It creates the link between refugees, HIV/AIDS and national policy responses to this population group. Within this framework, continued vulnerability can be a factor of the change in culture. Refugees may misinterpret promiscuous behaviour as norm in the new country and may adopt these “norms”, increasing risk of contracting HIV/AIDS (Shtarshall & Soskolne 2002). Increased vulnerability to HIV/AIDS can also result from an absence of culturally appropriate information on HIV/AIDS (UNAIDS 2001). Certain aspects of HIV/AIDS prevention touch sensitive aspects of refugees’ lives, such as intimacy and sexual relations. Such topics therefore need to be handled sensitively.

Post-migration vulnerability may also be enhanced by the unwillingness of a host country to invest in health policies for migrants (UNAIDS 2001). Many national health care plans discriminate against refugees by excluding them completely, or by limiting their service delivery to emergency care only (Spiegel & Nankoe 2003). Thus a refugee’s vulnerability can also be affected by restricted or even no access to public health care in host populations (IOM 2002). Most public health practices focus on collective or organized action interventions that protect only the host communities from potential disease threats introduced by migrating populations. Meanwhile, migrants also have needs that include access to medical treatment and other health interventions. In addition, migrants have their own health profiles and beliefs, which reflect the disease prevalence of their community of origin, which are often different from those of the host communities (Nguyen & Stovel 2004). These health profiles may inhibit the attainment of the intended public health impact on migrants where the host countries’ approaches to healthcare are culturally inappropriate to the newcomers, or where diseases unknown to migrants are present in transit or host communities (UNAIDS 2001). In the case of refugees in Cape Town, for example,

most of them are French speaking and have cultural backgrounds different from those of the host populations. These factors would need to be considered in the design of the South African public health policy and the HIV/AIDS strategic plan. Thus there would be a need for an integrated approach that includes all population groups and is sensitive to the health needs of migrants.

These disparities in health culture between the migrant and host populations have sometimes resulted in public health fears that have justified the old approaches to migration of quarantine and control (IOM 2002). The United States of America, Canada, the United Kingdom and many other countries have instituted controls of migrants entering their countries by demanding HIV/AIDS and tuberculosis tests as part of the application requirement for asylum seekers' permits. Current studies testify, however, to the ineffectiveness of screening and quarantine for these communicable diseases, which has led to individuals evading immigration controls and medical services rather than presenting themselves legally, for fear of being refused entry or deported (UNAIDS 2001). Coerced HIV/AIDS tests have no human rights basis. Luckily for refugees in Cape Town, South Africa has no HIV/AIDS or related disease basis on which an asylum seekers' permit can be provided.

The case of HIV/AIDS has also pushed the debates beyond the communicable diseases sphere of public health to the political economic cost of migrants. An example of this is England (among others), which has questioned the country's obligation to 'outsiders' at the supposedly high cost to the national health system (AVERT 2005). Despite this, independent assessments in the UK have suggested that such assumptions of increased costs are not based on facts, but that they have sometimes been used as a control mechanism (AVERT 2005).

However, some types of program responses to HIV/AIDS for refugees do exist in many countries that host such a refugee population group, including South Africa, and Cape Town in particular. These programs are sometimes guided by some best practice standards, which are normally a documentation of a continuous process of learning, feedback, reflection and analysis of what works or does not work. In their capacity as a global authority on HIV/AIDS, UNAIDS has thus documented best practices that have been viewed as authoritative in many countries. This research is based on a comparison between the current practice in South Africa and the best practice guidelines developed by the UNAIDS (UNAIDS 2001). This Report proposes the following components of country level HIV/AIDS interventions for refugees:

a) To focus on areas most frequented by refugee

The BPGS propose that HIV/AIDS prevention efforts be focused in zones where there is increased likelihood that risky behaviours will occur and HIV will be encountered, for instance truck stops, bus and train stations, harbours, and markets. In the case of refugees, this would also mean targeting their neighbourhoods. This exercise must try to avoid causing stigmatisation, because stigmatisation and shunning can increase the tendency of people to deny the issue; it can also cause anger, and sometimes alienate people with HIV/AIDS, and in the case of refugees, even drive them into hiding.

b) To implement programs that cross national borders

Refugees often move back and forth across borders and in the process increase their own levels of vulnerability due to mixing of populations of differing prevalence rates. Such movement back and forth can result in refugees being affected by differing qualities of healthcare programs and different access to healthcare across borders. HIV/AIDS services that are designed to operate across borders in the first place can offer a minimum standard service that can include full comprehensive services for migrants. Such a so-called 'one-stop-shop' clinic in all the most frequented spots along the migration routes is necessary to reduce vulnerability to HIV/AIDS. It would also enable refugees to access health care anywhere and would help with medication compliance for those on ARVs, who need a continuous and reliable supply of these drugs.

c) To conduct Pre-departure briefings, as well as post-arrival and reintegration programs

When refugees arrive in a country of destination, they are often confused and in need of social, economic and moral support, and they need to be integrated into their new communities. Upon arrival, then, briefings of where to get HIV/AIDS support can have a significant impact on their knowledge base of what services are provided for them. Moreover, when they return to their native countries, pre-departure briefings can help them to understand the differing prevalence rates, the services available to them in their countries of origin, and the cultural differences they may experience.

d) To improve the legal status of and legal support for refugees and their families

The level of access to healthcare for refugees starts with them having a legal status in the destination countries. The refugees whose status has been cleared and who have a legal ID

are covered by international laws in terms of healthcare. A legal ID also enhances access to job opportunities and social security grants. With regard to HIV/AIDS, refugees' vulnerability can be mitigated by access to these rights when they have access to social services. Thus, an effort could be made to enhance quick and easy access to legal permits for asylum seekers.

e) To include refugees into national policies

Targeting refugees at national level through setting operational goals and budgets can only be achieved when refugees are included in national HIV/AIDS policies. Inclusion into these policies is a statement of commitment at government level to this population group (UNHCHR 1996).

f) To update surveillance data and conduct research

The UNAIDS BPGS considers health surveillance data to be pivotal to providing public health decision makers with reliable and timely information in anticipating the size and nature of the pandemic over time (UNAIDS 2001). Good-quality surveillance systems are a pre-condition for effective response to HIV/AIDS. These data should provide continuous and comparable information on risky behaviour, as well as information on prevention, care and treatment services. It should also link data from various sources to create a full picture of the pandemic. The new public health approach proposes that the use of information to prove scientifically that there have been epidemiological shifts and to calculate potentially harmful risks, will enable people to take responsibility for their own health. It will also put every population group on the same level (UNAIDS 2001).

However, evidence has shown that it is important to treat epidemiological data relating to HIV/AIDS with caution. When the prevalence of HIV/AIDS among immigrants is higher than in the general population, the data can increase their exclusion from and stigmatisation by the general host population, further increasing their risk.

g) To manage relationships between health personnel and refugees

Better management of the relationships between health personnel and refugees can make health care facilities more accessible and user-friendly to refugees. This is mainly because refugees with HIV find it more difficult than the general population to maintain continuous relationships with health centres. Health workers may furthermore find immigrants' relationship patterns or sexual practices hard to deal with or even

reprehensible (Speigel & Nankoe 2003). The resulting frustrations and loss of confidence can lead to reluctance to return for follow-up care and sometimes to loss of contact with the health centres. Mediation by trained people from the immigrant population could help health personnel to establish a more understanding staff-patient relationship, and it has been known to be successful in increasing the rate of follow-up visits (BMA 2005).

h) To ensure that programs are culturally and linguistically appropriate

Efforts should be invested in establishing culturally and linguistically appropriate forms of outreach in HIV/AIDS programs that are targeted to migrants and mobile people. Culturally specific messages, projects and interventions are based on such principles that find ways of conveying messages that may fit or approximate the desired messages on HIV/AIDS. One such method is the one based on the traditional modes of communicating cultural lore to introduce new content (UNAIDS 2001).

i) To facilitate participation by refugees in the design of programs

Refugees need to participate in the design of HIV/AIDS programs targeted at them, firstly, in order to establish ownership of programs, and secondly, to integrate the differences between the migrant's culture and the host population's culture. This is because a migrant goes through a transition between two cultures and develops some specific old culture responses to host culture phenomena. The migrant therefore can comprehend both the history of their co-migrants' health beliefs and the transition that they are going through. Their contribution to the design of programs would help to identify the real needs to be addressed by these programs.

Moreover, HIV-positive refugees have more barriers than just culture to overcome, such as suspicion, fear and anger, which are common responses when people are informed about their positive HIV/AIDS status (Shtarshall & Soskolne 2002). The refugee leadership may help overcome these barriers by participating in both the design and implementation of HIV/AIDS programs, because they are in a position to understand the HIV-positive refugees better.

Notwithstanding the above points, the UNAIDS BPGS, in spite of being sound and practical, have not always been adopted by countries around the world. This may be because BPGS are not authoritative documents, but merely a guide to the design and implementation of programs and a basis for comparison of programs to the standard practices. Thus their adoption in

government sectors and public institutions has been dependent on, among other things, the presence of the right policy environment, support from leadership and involvement of stakeholders. Thus the inclusion of other stakeholders in the policy process can increase effectiveness as it allows more sharing of knowledge and resources between the civil service and governments don't have, for instance the sharing of BPGS (Provan & Milward 2001). The adoption of best practices also depends on adequate funding, an appropriate transfer plan and the existing capacity of the organization to adapt constantly to changing circumstances, both internal and external (Gertler 2001). Moreover, best practices within specific countries might not be repeated in other parts of the world, due to the unique specificities of situations in which they have been implemented (Gertler 2001). The networks theory also provides a basis for analysis of the extents to which the BPGS are absorbed by analyzing the nature and extent to which there has been sharing resources.

2.3 Conclusion

This chapter has reviewed the available literature on the links between refugees, their vulnerability to HIV/AIDS and the role of public policy in guiding response initiatives. The social ecological framework was used to describe the factors of conflict that affect refugees' vulnerability to HIV/AIDS. Also discussed was the role of public policy in influencing responses to that effect. This chapter also discussed the role of networks as the basis on which BPGS are brought into the policy process, and introduces the role of the UNAIDS BPGS for migrants in creating a standard for response and influencing policy. The next chapter places refugee HIV/AIDS responses within the public policy discipline and introduces the theoretical frameworks of the policy process. The chapter also discusses the development of public policy on refugees and HIV/AIDS, and finally locates the South African refugee HIV/AIDS policy process within that development.

CHAPTER THREE

3.1 Refugees, HIV/AIDS and Public Policy

3.1.1 Introduction

Successful public health strategies for HIV/AIDS demand integrated approaches, composed of promotion and prevention strategies, medical care, community care, counselling and social welfare services (UNAIDS 2001). All SADC member states have policies on HIV/AIDS and treatment guidelines, and some are developing explicit treatment access policies (EQUINET 2003). Refugees are normally not included in national public policies, however, partly because they do not always form part of the public agenda. For instance, none of the SADC countries that host refugees have HIV/AIDS policies and practices that support refugee rights or that they view refugee health programs as being a UNHCR responsibility (Bayard 2004). Of the twenty-two African countries with over 10,000 refugees, only fourteen have HIV/AIDS National Strategic Plans that mention refugees.

It is my contention that refugees need to be included in the national HIV/AIDS public policy framework if there is to be a more consolidated and purposeful response to the pandemic. Public policies can guarantee national commitment to such a coordinated approach and can create or be built into a supportive policy environment, which is necessary for successful implementation. The failure of governments to incorporate displaced persons into their national HIV/AIDS activities and surveillance systems has already had serious implications for refugee HIV/AIDS programs; for instance, it has resulted in the continued absence of refugee HIV/AIDS surveillance data. Data about the prevalence of HIV/AIDS among refugees is particularly difficult to get, because refugees are frequently not systematically included in HIV/AIDS surveillance systems. Uganda and Senegal, in contrast, have developed relatively successful HIV/AIDS surveillance and prevention systems, and yet virtually no specific data exists about the HIV/AIDS status of their large refugee populations (EQUINET 2003).

Nonetheless, national governments do have an obligation to provide healthcare for refugees and where that obligation has been fulfilled, public policy formulation on HIV/AIDS for refugees has been strongly influenced by the human rights approach to health. There are three international human rights laws that form the basis for public policy on HIV/AIDS for refugees, namely: the “Convention on the Status of Refugees” (1951), the “Universal Declaration of Human Rights” (1948) and the “Four Geneva Conventions” (1949). These laws guarantee refugees the

right to health in their host countries. These human rights frameworks furthermore provide a useful basis for understanding and addressing the vulnerability of refugees to HIV/AIDS through public policies. The rights framework sets precedence for the design of policies that would address societal and contextual factors that determine vulnerability, and that would analyse how approaches to HIV/AIDS may either protect or violate human rights. The human rights framework guides the formulation and implementation of public health policies that ensure health outcomes in respect of refugees' right to health.

3.1.2 Brief history of Public Policy about HIV/AIDS and refugees

In spite of these international laws, focus on public policy responses for refugees by host governments has taken much longer than efforts for host populations. Most of the influence in the policy development process has in fact come from international agencies. The first noticeable debates on refugee HIV/AIDS public policies only took place around 1992 and 1994; about ten years after the problem first arose among refugees. The Commission for Refugee Women and Children produced a conference report in 1994, entitled 'Refugee Women and Reproductive Health Care: Reassessing Priorities' (McGinn 2001). That report introduced some of the first strategies on refugee HIV/AIDS programs. Since the publication of McGinn's report, significant amounts of progress in policy development – some more comprehensive than others – have been made. One of these was the 1998 reproductive health kit for emergency situations, which was merely a list of supplies essential for reproductive health (UNFPA 1998). The UNFPA immediately used this kit for policy implementation. The Commission for Refugee Women and Children was not the only organisation drafting policies for refugee programs in that period. Other NGOs, such as the Médecins Sans Frontières (MSF) were drafting their own HIV/AIDS policies (McGinn 2001).

The contribution to policy development of the main global authority on refugees, the UNHCR, started in 1992, with a statement of policy and guidelines regarding refugee protection and assistance and HIV/AIDS, which was later updated to "The Policy regarding Refugees and Acquired Immune Deficiency Syndrome (AIDS)1998" (McGinn 2001). This latter policy, while outlining actual strategy for programs to follow, was also the start of a debate on the host government's responsibility to develop public policies that are inclusive of refugees in their countries (McGinn 2001). These policies would be developed and implemented in cooperation with the partnering intergovernmental, non-governmental and local community organizations. In

2002, the UNHCR introduced its current 2002-2004 Strategic Plan on HIV/AIDS and Refugees, which contains clear guidelines on standard practices for comprehensive responses to HIV/AIDS, with a public health orientation (Spiegel & Nankoe 2003).

The IOM's role in policy development started in the early 1990s in the form of prescriptive guidelines on handling migrants in the screening for HIV/AIDS (IOM 2005). More comprehensive policy development occurred in 1997, in cooperation with UNAIDS, in a joint project that reviewed literature from areas hardest hit by HIV/AIDS in the East, in Southern Africa and in South America (IOM 2005). In an effort to enhance the policy process in IOM, a position for an HIV/AIDS co-ordinator at headquarters level, temporarily funded by UNAIDS, was created. Moreover, a joint memorandum between IOM and UNAIDS was signed in 1999 that would increase advocacy for HIV/AIDS among migrant and mobile populations at international level and with host countries. This agreement signified the start of influence by these global institutions on the development of national and regional AIDS strategies that included vulnerable migrants (IOM 2005).

Response at much higher and more crucial UN levels has only been noticeable in the last five years. The realisation in 2000 amongst the peacekeeping services of the UN Security Council that HIV/AIDS cases are indeed escalating, gave the necessary momentum to develop policy to effect change within areas affected by conflict. The World Health Organization (WHO) was the first to develop such a policy document in April 2000, entitled "Controlling the Spread of HIV/AIDS in Complex Emergencies in Africa" (Smith 2002). Three months later, in July 2000, UN Resolution 1308 was passed, which further recognized the role of member states in aiding UN agencies to develop effective HIV/AIDS prevention strategies for peacekeeping missions (Smith 2002). A significant follow up policy from that resolution was the 2001 draft paper, "UNAIDS Steering Committee on HIV/AIDS as a Security Issue" (UNAIDS 2001).

However, in spite of these brief yet comprehensive policies at both international and national levels, implementation has been slow and thus the policies have been known to be stronger on paper than in practice (Bayard 2004). While the international agencies working in conflict-ridden countries have funded their own HIV/AIDS strategies and policies, not all have implemented these policies as planned. A study conducted by the Commission for Refugee Women and Children in September 2000 revealed that, amongst US-based international NGOs providing or supporting refugee reproductive health services, only 22% were addressing HIV/AIDS (McGinn 2001). As recently as 2005, in Cape Town, only one NGO namely the

PPASA was addressing refugee HIV/AIDS issues. Furthermore, host governments have seldom shown support of refugees' rights through their national policies either. Even where international agencies have funded host countries' HIV/AIDS proposals, refugees have still been consistently been left out (Spiegel & Nankoe 2003). A 2002 UNHCR review of the efforts by the Global Fund to Fight AIDS and the Multi-Country HIV/AIDS Programme (MAP) funded by the World Bank in 25 of the 29 refugee-hosting sub-Saharan states, only five programs included activities for refugees (McGinn 2001). In South Africa however, refugees are included in the national HIV/AIDS strategic plan and are funded by either the UNHCR or the state funded refugees' HIV/AIDS programs or sometimes both.

Even in those countries where refugees are incorporated into national policies, there are still policy issues that affect only refugees and not host populations. For instance, there is still a lack of consensus both within and across countries with regard to the provision of antiretroviral treatment for refugees with HIV/AIDS. Policy discussions range from possible cost increases, inability to maintain the provision of such drugs, effects on access to treatment arising from population movement, and reduced treatment efficacy if drug-resistance arises because of non-compliance (EQUINET 2003).

A lack of homogeneity is also noticeable in policy implementation, as this is determined by the national policy environment. Most developing countries have inadequate resources in any case, which lead to poorly financed healthcare systems, with a shortage or complete absence of services in the treatment and care sector of the comprehensive HIV/AIDS package. These packages are inadequate for their own nationals and for migrants in particular (EQUINET 2003). South Africa, in contrast, does have enough financial capacity to fund a full-fledged comprehensive HIV/AIDS country initiative that includes refugees. Nonetheless, there is a lack of capacity in other areas, which is manifested most importantly in the lack of qualified human resources and the lack of political leadership (Schneider 1998).

With regard to refugees, then, the UNHCR' review of their HIV/AIDS programs in Africa concluded that, within the response strategies, there is a wide variety of standards, quality and comprehensiveness among HIV/AIDS programs implemented in refugee populations (Spiegel & Nankoe 2003). There are also few culturally appropriate interventions, a high presence of HIV/AIDS discrimination, stigma against refugees, and a lack of funding and technical expertise, all of which severely hamper HIV/AIDS programs in refugee situations (Bronwen 1998).

Industrialized countries have also been known to add extra barriers to healthcare access, even for legal migrants through supporting agencies. For example, the US government, believing that there are too many migrants accessing healthcare, passed a law in 1996 that limited social security to US citizens only (UNAIDS 2001). Such a law seriously enhances a migrant's vulnerability to HIV/AIDS, because social security may be the only source of income that would enhance their enjoyment of the right to health.

3.1.3 Conceptual frameworks of Public Policy

When developing policies, specific processes are followed, depending on the nature of the policy. The general process consists of the policy formulation phase, the consensus-seeking phase, the implementation phase and the monitoring phase (Wissink & Cloete 2000). Many models have been developed that attempt to describe public policymaking processes. While not one such model can claim to depict the actual process accurately, many give adequate frameworks that explain the nature of policymaking. One such model is the elite model of policymaking, which, simply, says that key policy decisions are made by the elite few, whereas the remaining role players are depicted as a passive mass of people, who merely accept those decisions (Stover & Johnson 1999). Essentially, this is a top-down model with the elite in charge at the top.

Another model is called the group model of policymaking process ((Stover & Johnson 1999). This model emphasises the role of interest groups in policymaking. The assumption is that various interest groups exist on the policy forum, each advocating their own interest. The resultant policy outcome is produced through debate, negotiation and agreement between all the interest groups.

The institutional model draws attention to the role of departments and other bodies in government in the policy process. This model proposes that, since government legitimises policy, government institutions have a strong influence on the type of policy outcomes that emerge from policy discussions (Wissink & Cloete 2000). The social interaction framework, a fourth type of model, focuses on the nature and results of the negotiation, participation, mediation and conflict resolution that take place during policy formulation.

A model that may be more relevant to this research is the systems model, which proposes that policy is linked to the type of political system in place in the country. The systems theory acknowledges the contributions of all stakeholders to the policymaking process. Within the

systems model is a specific type of model that's more relevant to this research which is the policy network and communities' model. This model introduces the role of external agencies in the public policy process. In terms of this model, policy decisions are not taken by a single decision maker but are outcomes of negotiations between networks of policy stakeholders, both inside and outside the policy sector. These stakeholders meet to coordinate policy decisions and feed them back to formalised structures for ratification of the informal agreements reached. In South Africa, then, the inclusion of refugees into the national HIV/AIDS policy has been a product of efforts by external agencies. Since 1999, the IOM and UNAIDS have called for forums to discuss the role of the state in providing HIV/AIDS response initiatives to migrants. The first component of the policy formulation process is the identification of problems that end up on the agenda.

Within the described policy making models, the actual steps taken to reach policy consensus are also varied. The general initial step is the identification of a problem as a policy issue. A problem is identified and articulated during the agenda setting phase. Some problems only come onto the agenda when they have reached crisis proportions and cannot be ignored by government, and also when they have a much wider impact that is felt in every aspect of human life (Wissink & Cloete 2000). HIV/AIDS is one such problem that has quickly become a global issue, and thus national governments have been called upon by the international human rights body to work with all other existing institutions in responding to this issue. Sabatier (1998) (as cited in Ekins & Johnson 2003) demonstrates how in the example of HIV/AIDS, a problem has been highlighted as a policy issue onto the agenda by those who wield power.

This has been apparent in South Africa where the definition of HIV/AIDS and refugees and other migrants as a national policy problem was initiated by IOM, UNAIDS and UNHCR, who have energetically used both the human rights framework and their own resources to keep the issue on the policy agenda. UNAIDS has, for instance, paid for workshops to start the policy discussions, whereas UNHCR has a budget allocated for refugee HIV/AIDS activities and coordinates these funds in collaboration with the government and partnering organisations, such as the PPASA.

The identification and placing of a policy issue on the agenda is only the start in the policy phase however. Public participation is equally a key component of public policy if that policy is to be owned by the public. In the process of policy formulation, public participation can consist of four different types of involvement: (i) ratification, where decisions are approved; (ii) consultations, in which an audience is elicited for opinions; (iii) negotiations, in which parties

are directly involved in discussions; and (iv) execution, which means direct involvement in planning, drafting, implementing and evaluating policy programs (Wissink & Cloete 2000). Participation can be solicited by either individuals or interest groups within the community, or by an organisation or even an agency organisation working in the community. The nature of participation is legitimate if – in the case of development agencies – consideration is given to the needs and priorities expressed by the host community. In South Africa, public participation in the debates around HIV/AIDS and migrants and refugees has been solicited by the UNHCR and NGOS as refugee representatives. These organisations have sought an audience amongst the representative government public institutions at the policy forums. There are thus various models that can be used to describe the actual policy steps some of which can be applied to the HIV/AIDS policy in South Africa.

The first such model is the linear model of policy process according to Meier (1991) as cited (Stover & Johnson 1999). In this model, policy is composed of five stages, namely the prediction stage, the policymaker's stage, the policy choice's stage, the implementation stage and the outcome stage (Stover & Johnson 1999). In terms of this model, the policy process is initiated by the identification of a problem, which is followed by a stage during which alternatives at the policy makers' disposal are considered. During the next stage, a choice is made from among the available alternatives. Thereafter, the chosen policy is implemented, and lastly, the expected outcome becomes reality and the original problem has been solved more or less satisfactorily. This linear method is criticised for proposing a simplistic and overly straightforward approach to policy making. The model is also criticised for ignoring the evaluation phase, and in so doing failing to connect the evaluation feedback to the policy process, thereby ignoring the essentially cyclical nature of the policymaking process (Stover & Johnson 1999).

Grindle and Thomas (1991) as cited in (Stover & Johnson 1999), similarly propose a model that starts with the agenda phase, during which an issue has a chance to get on the agenda. Once on the agenda, that issue has a chance only if the policy panel sees the need to give the issue attention; but even when the policy makes it to policy formulation stage, it may never be implemented at all (Wissink & Cloete 2000). This model is weak in describing the role of the donors that keep certain issues on the agenda even as the policy process goes through different phases. The model also fails to acknowledge that some issues such as the HIV/AIDS for refugees pertain to international human rights and they cannot be removed from the policy agenda. The

model however is accurate is pointing out that even when a policy reaches the policy formulation stage, it may never be implemented at all (EQUINET 2003).

Porter (1995) (as cited from Wissink & Cloete 2000) proposes a model where three elements of policy have to come together at the same time if a policy is to be formulated: i.e. problems are identified, solutions are proposed and political openings are all present at the same time. An issue will only survive on the policy agenda if an elite member of the policy forum advocates keeping it there.

None of the policy models discussed above is an accurate description of the agenda setting process for the refugee policy in South Africa. The best description may be given by the Walt and Gibson model.

Walt and Gibson (1994) (as cited in Wait 2004) acknowledge the role of many players on the policy forum in the policy process. The key players are categorised as:

- (i) Technical experts, who prescribe the problem, advocate for it and seek to see the outcome;
- (ii) The bureaucratic officers, who inform the policy forum on government's capacity and capability to address the problem;
- (iii) Interest groups, who represent certain population groups and fight to get their issues on the agenda;
- (iv) Politicians, who are the decision makers; and
- (v) Donors, who support certain policies with funds and provide technical support

All the models show that policy making phases are never a simple and straightforward process, however, as seen in the case of policy development in South Africa with regard to HIV/AIDS and its effects on refugees and migrants. Between 1999 and 2000, the making of policy for refugees and other migrants went through many phases. The Walt and Gibson model is closest to depicting the HIV/AIDS policy agenda phase in respect of migrants, as it encapsulates the role of the major stakeholders who have been heavily influenced by multi-national donors and interest groups representing the issues of refugees. These donors keep the migrants' HIV/AIDS issue on the policy forum by providing funding and technical aid and debating the human rights obligation of the national governments.

A supporting theory to the Gibson theory of policy influencers is the theory of networks. This theory goes further in the analysis of the role of stakeholders in partnering with government

in the policy process, by emphasising that networks influence policy at all spheres of policy. The theory also endeavours to explain the nature of internal relationships within networks and how they affect the extents to which these networks are effective in public service delivery. The theory proposes that the networks' effectiveness in the public policy process or lack of it depends on the extents to which stakeholders consciously coordinate their collective pool of resources through sharing between the government, with its characteristic resources incapacity, and other resource rich partners (Provan & Milward 2001). The principles in this theory would be useful in understating the nature of the refugee HIV/AIDS policy process with regards to the extents to which the BPGS are absorbed.

3.1.4 The relationship between Public Policy and Public Administration

Public Policy is the statement of desired goals established by the state, and the process of making policy is complete only when policy becomes law (Starling 1993). Once policy has been made, the process of attaining the policy goal is the responsibility of the public administrator, which makes public administration to be the administrative side of government (Coetzee 1988). Therefore, public policy creates the task that administrators must accomplish and how they must accomplish it (Gartner 1981).

Public administration is conducted through organizations and institutions called public enterprises or institutions (Gartner 1981). These institutions implement policy under the guidance of national Public Service Acts. In South Africa, the Public Service Act of 1994 (proclamation 103 of 1994) guides the implementation of policy. The Act stipulates that public administration must be governed by the democratic values and principles enshrined in the constitution. The Act emphasizes the role of public service in public administration, and stipulates that public service must function and be structured in terms of national legislation. The Act further stipulates that principles of public administration should broadly include representation of citizens' needs and wishes, accountability, efficiency, professionalism, equitability and fairness. The Public Service Act grants public institutions the mandate to carry out their administrative functions of planning, organizing, staffing, directing, coordinating, reporting and budgeting.

The relationship between Public Policy and Public Administration is that of a continuous and cyclical nature. This is because administrators do not only carry out the policy mandated by legislation, but are also engaged in the policy making process as much as elected officials are

involved in the administration of policy. As they carry out their duties, they may develop new ideas of administering which they may propose for inclusion in policy. Some of their contributions may include recommendations for the amendments of existing laws. For instance, during the provision of refugee HIV/AIDS service, the department of health may recommend that government be linguistically sensitive in the provision of refugee healthcare services and therefore every hospital must have interpreters. Thus public administrators both systematically formulate and apply policies, creating a relationship between policy and administration called policy administration continuum (Frederickson & Smith 2002).

Public administration consists of six processes namely policy making, organising, financing, controlling, personnel management and managing methods and procedures (Botes et. al 1992:188). However, the success of public administration lies within the administrators' ability to use the instruments of planning and decision making processes to attain policy goals (IIAS & UN 1997). This process requires both adequate and efficient management of human, financial and material resources to meet these goals. In South Africa, human resource incapacity has been known to affect the delivery of public services. For instance, from 1997 to 2003 the state reduced the number of public servants by 13% to only 1.1 million. This number was not sufficient to manage the whole public service and consequentially, many departments had serious human resource shortfalls, which made it difficult for the departments to expense their budgetary allocation. In 2004, the department of health had at least 27% of health professional posts and 60% nursing posts unfilled (Ruiters 2005).

Administrators have not only to manage existing resource capacity challenges in their own institutions, but also have the challenge of managing these capacities within complex policy frameworks, where there is interaction between governments, national and international non-governmental stakeholders (IIAS & UN 1997). Within these frameworks, governments may depend on administrative capacities of other stakeholders in the delivery of public services. Thus, administrators have to manage not only their own capacity constraints and opportunities but also manage the effects of challenging structural and systemic constraints presented by the inclusion of other stakeholders. Thus insufficient budgetary, human resources and other resources in one or more of these institutions may either be an opportunity to share and transfer knowledge and skills between the partners, or may derail the absorption of shared knowledge into policy. Furthermore, administrators must play the multiple role of providing the necessary legal framework while retaining the core function of policy decision and still be responsible for the public service

outcomes. Successful administrators are those that manage this complexity well (IIAS & UN 1997).

The function of human resources management is a key administrative objective in determining the extent to which the refugee HIV/AIDS service is delivered. Therefore, effective human resource development targeting specific needed skills would be necessary. Furthermore, human resources within all stakeholder institutions may benefit from training that increase the knowledge about refugee plight and lifestyle, their human rights and their cultural and ethnic challenges that impact on their public health outcomes. These trainings would need to be conducted in coordination within the network of stakeholders.

Coordination and consultation is another key function in the administration of the multifaceted refugee HIV/AIDS policy and requires clear consultative, effective communication and consensus on policy issues. Thus, a culture must exist in both the government and non-governmental organization that allows sharing of resource capacity. This policy network may need to develop institutions, for instance task forces or committees to enhance effective consultation, communication, and sharing of resources. Resource sharing may include the placing of interpreters in hospitals by the PPASA and distribution of culturally appropriate HIV/AIDS service and educational materials to refugees.

Lastly, the public administrative function of information management also determines the extents to which policy reflects the current global and national development trends (IIAS & UN 1997). Within the refugee HIV/AIDS policy making body for instance, quick acquisition and sharing of knowledge developments, for instance national refugee HIV/AIDS surveillance trends, global influences from new trends in migration theories, human rights developments and global best practices, must be part of the policy process.

3.1.5 Conclusion

Public administration includes policy making and its administration. In this research, policy exists within the public policy continuum, in which administrators are involved in the development and administering of policy. The public administration functions and their opportunities and constraints may affect the extents to which the refugee HIV/AIDS service is delivered. In the process of administrating, policy content may be shaped and influenced.

3.2 The Refugee Public Policy Process in South Africa

Prior to 1999, South Africa had no public policy statements on HIV/AIDS programs for refugees or migrants as such prior to 1999. Although ad-hoc practices within NGOs in partnership with private corporations, most of which took place within the mining sector, could be traced back to the 1990s, more consolidated policy debates on migration and HIV/AIDS only began in March 1999. At that time, the IOM, UNAIDS, government officials and NGOs participating in the migration field held their first policy forum in Pretoria (IOM 1999). This meeting was a result of the initiative of IOM and UNAIDS in bringing together the South African Departments of Home Affairs and Health. The main objective of these consultations was the development of a national policy that was in line with emerging issues at global level.

The policy debates amongst the IOM, UNAIDS, UNHCR and the government institutions culminated in the inclusion of a response to the HIV/AIDS pandemic among refugees and other migrants into the general South African HIV/AIDS Strategy 2000-2005. Thus it is clear that external agents have been solely responsible for defining the HIV/AIDS problem of migrants, including refugees. These agents have been key interest groups on the public policy forum, pushing for the inclusion of refugees with HIV/AIDS on the policy agenda. This type of policy process has been described within the public policy process framework as the 'policy network and communities model' (Wissink & Cloete 2000). In terms of this model, stakeholders from both inside and outside the policy sector can negotiate with other policy stakeholders on policy issues. The IOM, UNAIDS, UNHCR, NGOs and the national departments with activities relating to refugees thus make up the forum of stakeholders who negotiate suitable policy responses for refugees and HIV/AIDS.

The phases of the policy processes in South Africa can be depicted by the Walt and Gibson model, in terms of which the IOM, UNAIDS, UNHCR and other NGOs have acted as technical experts on the policy forum, while the government departments have played the bureaucratic role, informing the forum of government capacity in the policy process. How the South African situation differs from the Walt and Gibson model is that the external agencies, who are also the interest groups, have played multiple roles. In the Walt and Gibson model, in contrast, the role of interest groups is clearly different and separate from that of the donors, who play the role of donors only. In the case of South Africa, however, the IOM, UNAIDS and UNHCR have been the technical experts, the interest groups and the donors on the policy forum. Consequently, these agencies have been instrumental in identifying the HIV/AIDS problem relating to refugees

and migrants in South Africa, and thus have set the agenda in this policy too; in other words, they have partly funded the policy formulation discussions, as well as the policy implementation.

Other supporting Civil Society Organisations (CSOs), whose interventions directly or indirectly influence the status of refugees with HIV/AIDS in South Africa, can be divided into two categories. The first category is made up of state institutions, such as the Department of Home Affairs, the Department of Health, the Department of Social Welfare, the Department of Defence, the Department of Justice, and the Department of Education. These departments ensure that appropriate legislations and regulations are introduced, instituted and implemented to accommodate refugees, as well as nationals and all non-nationals, in such areas as refugee permits, legal protection, primary health cover, basic education and social and security protection (Radebe 2003).

The second category comprises non-state humanitarian actors who are divided into three sub-groups. The first sub-group are the international NGOs, such as the United Nations High Commission for Refugees (UNHCR); the Jesuit Refugee Service (JRS), the United Nations Children's Fund (UNICEF), AFRICARE, Amnesty International, the International Federation of the Red Cross, and the Red Crescents Societies (Radebe 2003). The CSOs involved in the final outreach programme included the South African Council of Churches (SACC), the National Paralegal Association (NORTRAPA), and the Institute for Democracy in South Africa (IDASA), and the Refugee Research Programme of the University of the Witwatersrand (Greenstein 2004).

Of this group of CSOs, those targeting refugee HIV/AIDS directly are UNAIDS, IOM, UNHCR, PPASA, Red Cross Crescent, the JRS, and the SACC. However, there is no homogeneity in the refugee HIV/AIDS programs across the country. In Cape Town, for instance, PPASA is the key CSO with a focus on prevention, while the CSO focusing on care and support is Catholic Welfare and Development. In Johannesburg, in contrast, the Red Cross Crescent focus on prevention, whereas the Jesuits are very instrumental in the care and support category.

All these stakeholders work within the broader national HIV/AIDS policy environment. Actual policy on HIV/AIDS in South Africa started in 1990, with the publishing of the National HIV/AIDS strategy as a policy document. The first traces of HIV/AIDS in South Africa were reported in the early 1980s. In the latter part of the 1980s, the disease became more prominent, and was linked to mining migrants entering the country from East and Central Africa. Between 1992 and 1994, concerted efforts were made by the policy formulation forum between multiple partners, leading to the formation of a national coordinating body namely National AIDS

Convention of South Africa (NACOSA) and subsequently to a policy statement on HIV/AIDS in 1994 (Schneider 1998). However, public policy debates on refugees and other migrants in South Africa only started in 1999, seven years after the start of the development of the first national HIV/AIDS policy. Even though the first national strategy on HIV/AIDS was in place by 1994, the first national policy that included refugees in South Africa is the current National HIV/AIDS Strategy, which covers the period between 2000 and 2005. The implementation of the HIV/AIDS policy in South Africa has been hampered by inconsistency and inadequately structured government institutions (Schneider 1998). These structures have also lacked financial and human resource support necessary to restructure them into more efficient and effective bodies (USAID 2001). The current national strategy for HIV/AIDS encompasses the following broad policy issues:

3.2.1 Priority area 1: Prevention

The goal of this policy issue is to promote safe and healthy sexual behaviour, to improve the role of voluntary HIV counselling and testing (VCT), and to improve the management and control of STDs by broad social marketing and promoting the use of condoms. Social marketing is crucial to dissemination of information and is pivotal in preventing sexual transmission of HIV through increasing awareness of the disease. In South Africa, broadcasts on television, radio and in local newspapers are the most common means of social marketing. There are, however, no materials targeting refugees, neither at national level nor in a language or cultural expression familiar to refugees (Swartz 2000). Within the framework of human rights, access to information on HIV/AIDS is a fundamental right, to which refugees are also entitled (UNAIDS 2001).

Other goals related to this priority area are the reduction of mother to child transmission (MTCT), as well as addressing issues relating to blood transfusion and providing appropriate post-exposure services. In theory but not practice, refugees can access these services at hospital centres in the same way as all citizens of the host nation. The weaknesses of these policy goals are their lack of emphasis on the language rights of refugees at the point of healthcare service and the lack of culturally appropriate healthcare available to refugees.

3.2.2 Priority area 2: Treatment, Care and Support

The objectives of the treatment care and support focus areas are, as the name says, to provide treatment, care and support services in both health facilities and communities, and to develop and expand services of care to children and orphans.

In terms of the treatment goal, refugees are permitted to visit public hospitals and health centres that provide HIV/AIDS treatment. The treatment of HIV/AIDS entails counselling of the patient at the point of care and following up to enhance adherence with treatment. The hospital centres would thus be expected to have in place a language policy, to make available interpreters for non South Africans, and to implement mechanisms to follow up on migrants that have started treatment. The 2004 report by the UNHCR indicated that, despite these expectations, refugees' treatment is sometimes delayed, and sometimes not offered at all, due to the absence of interpreters. The role of follow-ups of patients on treatment to enhance adherence is also not well developed.

The absence of strategy for refugees under the Treatment, Care and Support objective is also apparent in the lack of integrated perspective in the many efforts by many other institutions in the migrants' HIV/AIDS sector. For instance in 2002, the National HIV/AIDS Review reports (GOV 2003) on the target focus areas; indicates that at the national departmental level, all national government departments and the majority of provincial departments provide basic HIV/AIDS related services. Some examples in the national departmental efforts to HIV/AIDS according to GOV (2003) are the Department of Transport (Trucking against AIDS), Labour (Code of Good Practice on HIV/AIDS), Land Affairs (programme for land reform) and a partnership between SAPS, Defence, Correctional Services, and Health (the Civil Military Alliance). Interestingly, there is no mention in the policy of initiatives from Home Affairs for instance, on collaboration with other departments for refugees or asylum seekers living with HIV/AIDS.

This evident lack of integration has also affected the allocation of budgeting and building adequate capacity of all HIV/AIDS initiatives. Thus, at the level of implementation, responses such as the one of the PPASA, where the whole budget is allocated only to the prevention program, or Victoria Hospital, where there is neither financial capacity nor skilled human resources to ensure the inclusion of refugees in the HIV/AIDS strategy, reflect a lack of integration. The lack of coordination may also be a result of the already un-integrated, multiple and parallel nature of the structure within which the general HIV/AIDS initiative is implemented in South Africa (Schneider 1998). It may also reflect a lack of political will behind refugee HIV/AIDS initiatives. Schneider (1998) argues that groups such as NACOSA have successfully lobbied for presidential leadership and have coercively managed to integrate all national ministries and government departments in formulating policy on AIDS. However, the implementation at interdepartmental level still lacks political commitment (USAID 2001). With

regards to refugees, the lack of integration of refugee HIV/AIDS in all national ministries may indicate that the efforts by NACOSA have sidelined refugees.

3.2.3. Priority area 3: Research, Monitoring and Surveillance

This policy objective focuses on the aspect of HIV/AIDS that promotes the development of an AIDS vaccine, investigates treatment and care options, conducts policy research and conducts regular surveillance. The focus areas that are of direct relevance in this regard are those pertaining to the conduct of policy research and surveillance in such a way that they are reflective of refugees' lives. In the case of South Africa, this information would provide a situational analysis of the levels of vulnerability that exist amongst refugees; it would furthermore enhance the quality of disease management, and help to forecast future trends and thus to design better future responses. This would be in line with the UNAIDS recommendations, which encourages the pursuit of differential surveillance data on host and migrant populations, in which other data such as mortality and nutrition are collected and compared (UNAIDS 2001). There is neither a strategy nor any immediate plans to collect this type of information at public hospitals. In 1999, the ILO found that very little research had been done on the inter-relatedness of migration and HIV/AIDS (IOM 1999). As recently as 2004, though, even the UNHCR could not give basic trends of refugees with HIV/AIDS.

Such an absence of information can inevitably result in the allocation of budgets and other resources in an unscientific manner, and would lead to either wastage or under-resourcing of refugee HIV/AIDS initiatives, thus would lead to ineffective and inefficient usage of public funds. There is no clear scientific forecasting of the disease burden amongst the refugees in Cape Town that would justify the allocation of that budget for the whole city. Thus it is difficult to assess how those resources can be better spent. However, dealing with data in this way should be done with extreme caution.

3.2.4 Priority area 4: Human and Legal Rights

The goal of the legal and human rights policy area is to create an appropriate social environment and to develop an appropriate legal and policy environment for refugees. While broad universal human rights, such as the right to health and information, are adequately covered, other supporting rights, such as the right to receive treatment and care in one's own language, are weak in the actual implementation of the HIV/AIDS policy. Also not adequately translated are the effects of abuse of the right to non refusal of entry and permission to stay on refugees' access to

HIV/AIDS services. The abuse of this right was apparent in 2003, for instance, when 71% of all South Africa refugees were still without documentation, while 27% of applicants prior to April 2000 were still waiting for their documents in 2003. The requirement that patients must possess a legal ID number in order to see a public medical practitioner inhibits migrants without such documentation from seeking medical care (Robinson 2004). Ironically, contact with health agencies increases fear of exposure (Robinson 2004). Research on human rights demonstrates that, particularly with regard to HIV/AIDS, discrimination of any kind creates and sustains conditions leading to societal vulnerability to HIV infection, and inhibits the attainment of equitable access (Guskin & Tarantola 2001).

The South African refugee HIV/AIDS policy has, in any case, been viewed through the narrow lens of public health perception and not as an issue that essentially applies to all people, irrespective of race, gender or culture, and thus needing consolidation at all levels. There is no real understanding of the refugee-related HIV/AIDS outcomes in other policies within all the sectors of government, such as the Refugee Act and the Welfare Policy. The 1998 Refugee Act 130 (GOV 1998), which replaced the Aliens Control Act, only became effective in 2000, and it grants the right to non-refusal of entry and stay in hosting countries and procedural rights of asylum seekers as under the African Refugee Laws. In terms of this Act, a refugee has the same rights as a citizen, except for the right to vote (GOV 1998).

Despite such liberal legislation, however, South Africa holds a less than satisfactory human rights record with regard to migrants. One of the symptoms of this is that the general public does not distinguish between refugees and other types of migrants (Vaiji 2003). Refugees have thus been caught up in the same ill-founded generalisations that are made for other migrants. In the past and to some extent the present, refugees' rights have been denied in the following ways:

A. Xenophobia

South Africa has high levels of discrimination against migrants in general. Migrants are thus commonly considered to be different, a drain on resources, and responsible for such social ills as disease, poverty, crime, and loss of jobs (Vaiji 2003). The host communities recognise refugees by their skin colour, language and physical features, and these perceptions cause isolation and further inhibit access to healthcare (Debevoise & Plimpton 2002).

B. Stigmatisation

Stigmatisation is particularly likely to accompany diseases that are highly contagious, visibly identifiable or have serious or fatal consequences for carriers. It also tends to arise when a disease is seen to affect social groups who are already discriminated against, and when transmission is seen to be due to certain actions or behaviour. The UNAIDS guide to HIV/AIDS recognises stigmatisation as a violation of human rights. In South Africa, however, refugees and other migrants are partly blamed for the spread of disease; those who know they are infected consequently hide their HIV status for as long as possible, choosing not to access support services rather than being stigmatised (Vaiji 2003).

C. Employment discrimination

The definition of health as a right in international law is such that it encompasses socio-economic wellbeing as well (Bayard 2004). Apart from medical treatment, an HIV/AIDS patient requires good nutrition and a support system. For urban refugees, such as those in South Africa, this can only be achieved when they have a means of income or access to social welfare. In the light of this, the UNAIDS BPGS also propose that country programs dealing with refugees and HIV/AIDS help to integrate refugees into normal living conditions by enabling their attainment of legal status. International law and the national migration policy are both clear in stating that refugees with legal identity shall be accorded the same rights as citizens. But even as a resourceful community in South Africa, refugees experience difficulties in finding jobs, let alone a job worth their level of education.

D. The right of non-refusal of entry and stay and detention

In 2003, South Africa deported 41,207 Zimbabwean asylum seekers (Landau 2004). The best practice guidelines for migrants proposes that support be rendered to migrants in the attainment of legal status so they can have better access to healthcare and HIV/AIDS services. Those asylum seekers whose applications for legal asylum have been denied cannot access healthcare and are afraid of seeking such care for fear of being handed over to the relevant authorities as illegal immigrants.

In addition to the problems they experience with regard to acquiring a legal permit, refugees also fail to enjoy the rights granted in both the Constitution and the Refugee Act. Refugees, though entitled to welfare benefits in terms of the Constitution, are effectively denied that right in the Welfare Act. Section 3(c) of the Social Assistance Act excludes non South African citizens from accessing certain welfare benefits. Section 4(b) (ii) of the Social Assistance Act 59 of 1992 also excludes children of refugees from accessing child support grants (Pillai & Polzer 2003). The social welfare grant is sometimes the only source of income for those poor households that can access grants and other social benefits. Legal discussions around the application of the Welfare Act to refugees first reached the South African courts on the 12th of March 2003. During this case the Department of Welfare was ordered to pay child support grants to the applicants, and the Department was further ordered to receive and process applications on behalf of the other children listed in the application (Pillai & Polzer 2003).

3.3 Conclusion

In this chapter, then, I have provided a brief history of the development of the HIV/AIDS policy relating to refugees at a global level. The aim was to set out the policy process, the main players in the formulation of the policy, and the nature and problems of implementation. Thereafter, the policymaking process with regard to the refugee HIV/AIDS issue was discussed within the theoretical and conceptual frameworks of public policy. The many models of the public policy process were briefly discussed, and the South African policy processes were placed in both the general global context and within the framework of public policy.

The HIV/AIDS policy formulation process with regard to migrants in general in South Africa took a more rapid approach, with minimum participation from national government and intensive participation by external agencies and government departments. The scope of the policy response has been narrow, and it places refugees in the same category as host populations, instead of soliciting the commitment of other stakeholders in the enhancement of the HIV/AIDS response in their policies. Even when policies are in place, the nature of implementation is not homogenous at district or provincial levels, as there are no standard guidelines for implementers to use. The next chapter introduces the findings of this research on the implementation of the refugee-related HIV/AIDS programs in Cape Town in the two case studies.

CHAPTER FOUR

4.1 Research Findings

In this research, data was collected in relation to the two programs with initiatives for refugees with HIV/AIDS identified in the previous chapter, namely Victoria Hospital and PPASA. The data collection exercise consisted primarily of semi-structured interviews, each lasting up to two hours. The objectives of the questions asked in the interviews were, firstly, to document the practices, and secondly, to compare those practices to the UNAIDS Best Practice Guidelines.

The first part of this chapter will present the data findings from the two programs respectively, comparing them to the UNAIDS BPGS and showing the implications of deviations from the best practice guidelines on HIV/AIDS. The latter part of the chapter will discuss the findings within the public policy framework and the context of the adoption of the UNAIDS BPGS.

4.2 Case Study One: PPASA

A series of interviews were conducted with Easter, the manager of refugee programs at PPASA in Cape Town on 10 July, 25 July and 6 August 2005 respectively. The findings revealed that there are four refugee programs in Cape Town. Two of the programs, Scalabrinin and Bonne Esperance are temporary homes that shelter refugees. The third programme, ARESTA, is a capacity-building program, and the fourth program is PPASA, a large international NGO, specialising in reproductive health and HIV/AIDS services. The refugees' HIV/AIDS intervention is pioneered and run by PPASA and supported by the public hospitals. All hospital centres are by law required to offer free public healthcare to all refugees with valid IDs. PPASA also runs HIV/AIDS prevention programs at the two homes for refugees and the capacity-building program.

PPASA is the South African branch of the international organization Planned Parenthood Association. In Cape Town, PPASA offers health services with a particular focus on HIV/AIDS and sexual reproductive health and technical support to the South African host population and refugee population. The work done by this organization thus covers the prevention component of the comprehensive HIV/AIDS package. In addition to using social campaigns and condom distribution as key strategies to curb the further spread of HIV/AIDS, PPASA also offers training

on social economic disparities among refugees to all programs involved with refugees who are living with or affected by HIV/AIDS.

PPASA is the only refugee HIV/AIDS implementation organ of both the international UNHCR and the local Department of Health in Cape Town. These two are effectively the only sources of funding for refugee-related HIV/AIDS activities conducted by PPASA. The Association has furthermore facilitated the formation of an HIV/AIDS forum called Tutumike, comprised of all the refugee programs in Cape Town, which meets from time to time to enhance relationships between the various stakeholders, to improve coordination of activities and to monitor progress. PPASA is the HIV/AIDS specialist in this forum and thus provides technical aid to the other programs. It also collaborates with other non-refugee NGOs in providing care and support for refugees. Its program is based on the UNAIDS BPGS for migrants, recommended by the UNHCR, which answers the first research question in this research, viz. whether PPASA was aware of these guidelines. The interview questions, which sought to compare the present practice at PPASA with the UNAIDS BPGS, revealed that their programs do indeed comply with the guidelines. In fact, almost all the recommendations of the UNAIDS BPGS have been adopted by PPASA.

One of the recommendations contained in the UNAIDS BPGS is that HIV/AIDS initiatives be targeted at areas most frequented by migrants. PPASA has defined their refugee target groups as adult males, adult females and the youth. The targeting of their programs is thus based on the social living patterns of refugees, as these tend to conglomerate into clusters, based either on religion or on ethnic origin. Consequently, the outreach workers of the Association visit the refugees in their homes to pass on information on HIV/AIDS prevention. In addition, PPASA uses social campaigns by holding workshops and distributing pamphlets at refugee functions, gatherings and church meetings. During these interactions, condoms are also distributed, as is information about where to access reproductive health services.

PPASA also works with the Department of Home Affairs to help spread information about the disease and about available HIV/AIDS service points in Cape Town. PPASA also uses Home Affairs as a point of recruitment of refugees into HIV/AIDS programs. However, questions can be raised about the readiness of some refugees, especially those whose legal residence permits for whatever reasons have not been issued or authenticated to be visited by outreach workers at their place of residence. A further problem is that these messages would not reach those refugees who do not fit into standard residential or religious patterns.

Another recommendation made in the UNAIDS BPGS is that refugees be included in national budgets, which would allow funds to be committed to these programs. The interview with the representative of PPASA revealed that, not only does the government set aside a national budget for refugees through the Department of Health and thus relay these funds to PPASA; the UNHCR also provides funding to PPASA to develop, design and implement prevention programs.

While more than adequate funding is available for refugees in Cape Town, the purpose of such funding is only preventative. No funding is made available for care and support, or for the treatment of refugees. Effectively this means that the HIV/AIDS initiative relating to refugees only fits into the prevention category. Clearly, this limitation cannot be justified.

PPASA offers orientation training on issues pertaining to refugees at the major service points visited by refugees, such as the hospital centres and the Department of Home Affairs. In these training courses, hospitals have received basic information about refugee rights. The UNAIDS BPGS also recommends that HIV/AIDS interventions be made linguistically and culturally appropriate to refugees. Consequently, PPASA has had the necessary HIV/AIDS messages translated into the various refugee languages and distributed in the form of pamphlets and other readable materials. The organization also conducts workshops in refugee languages and places interpreters where necessary in order to enhance access to reproductive health and HIV/AIDS services. The interventions that are not interpreted, such as the social campaign “Love Life”, which is in the form of a youth magazine, remain in English because refugee youths tend to pick up languages more quickly than their parents do, and because most young refugees can converse quite satisfactorily in English.

PPASA also has helped place interpreters who can speak refugee languages (mostly French and Swahili) in hospitals (including Victoria Hospital). Whereas some interpreters have become full time employees permanently stationed at hospitals, others are available on call, as and when they are needed. The position of interpreter at Victoria Hospital is currently vacant, however, because the previous interpreter found a better job elsewhere. At the time the hospital staff were interviewed she had still not been replaced and that was six months since she had left. This failure to replace an essential interpreter is a key factor of this research, as it raises questions around the national policy on refugees’ language rights, particularly as it pertains to access to public healthcare, and how the effects of those national policies compare to the UNAIDS BPGS. The language factor was also the factor that the UNHCR found to be most common barrier affecting the extent to which refugees were accessing healthcare at South African public hospitals.

In summary, then, PPASA has done a good job of helping refugees to access HIV/AIDS services in their own language or at least in a language they understand. However, one weakness is that not all partner organizations are as well resourced as PPASA. These partners also do not specifically target their programs at refugees, but cater both for the public in general which is why they do not pay sufficient attention to refugees.

Lastly, the UNAIDS BPGS recommend that initiatives be cognisant of the role that refugees can play in designing their own programs. Thus the participation of the migrants in the design of their HIV/AIDS programs was compared with the design of initiatives at PPASA. The data collection process revealed that PPASA acknowledges that beneficiaries must participate in the design of HIV/AIDS programs, and thus have integrated the refugee youth and leadership, as well as influential refugees, such as the elderly and church pastors with large congregations of refugees, in the implementation of social campaigns and the dissemination of condoms. The obvious critique to the use of the elderly and church pastors is that refugees who keep away from the churches or who do not belong to any groups per se are thus not represented or targeted by these programs.

4.3 Case study Two: Victoria Hospital

Victoria Hospital in the Wynberg area of the Southern suburbs of Cape Town is a secondary care hospital that receives referrals of those who have tested positive to HIV/AIDS at primary health care centres in the Southern Suburbs. In the course of this research, separate interviews were conducted at Victoria Hospital with the doctor in charge of the HIV/AIDS program (Dr. Luker) and with two of his counsellors on 14th July 2005. The third counsellor, who had been identified prior to the interview, was absent from work on the day of the interview. The aim of the research questions was, firstly, to understand the program practices with respect to refugees, and secondly, to benchmark these practices against the UNAIDS BPGS.

It emerged from the interviews that the members of staff in the HIV/AIDS unit of the Victoria Hospital had never heard of the UNAIDS BPGS, and that refugees are offered the same service as the host population. The interview also revealed that refugees at this hospital are treated like everyone else. There is no special effort to deal with refugees as a unique group of people. For instance, their information is captured at the reception; then, the doctor follows the WHO protocol for all HIV/AIDS patients, gives the patients what they need and sends them away

without consideration of their life outside the hospital. The doctor at the hospital does not form interpersonal relationships with his refugee patients, as this is regarded as too time-consuming and as the doctor's time is valuable and needs to be spent on more urgent matters. This is partly because there is indeed a shortage of doctors at the hospital, which has led to a situation where there is one doctor for every 40 patients per day, as opposed to the recommended ratio of one doctor to every 20 patients per day. Research on refugees has revealed, however, that refugees want their health workers to be understanding of the situations in their home countries and to be aware of other social issues affecting them, such as the living conditions of their families members (Duchesneau 2004). Given the shortage of staff, these needs can clearly not be met. Apart from that, the staff shortage has led to other problems too, such as the failure of doctors and nurses to follow up on patients to ensure that they adhere to the ARV medication once they start. This is contrary to the UNAIDS BPGS, which recommend that the health personnel work with refugees to build useful relationships in order to enable better service access for refugees (UNAIDS 2001).

The hospital also has no resources to employ qualified counsellors. There are currently three counsellors whose highest education attained is a high school certificate. They all are part-time support staff and have never carried out any home visits, networking or follow-ups. The doctor in charge acknowledged that the calibre of his counsellors was inadequate for managing host population issues, and let alone refugee issues, explaining that those counsellors are barely able to provide standard counselling, and that, ideally, trained social counsellors at college level should be doing this job. The shortage of staffing also inhibits other related services, such as following up on the refugees on ARVs who fail to adhere to their prescriptions. This failure to follow up is also, however, a factor of the relationship between the CSO and the Department of Health, as it should be the responsibility of the CSO to follow up in collaboration with the hospital. The HIV/AIDS counsellors have limited knowledge of the places frequented by refugees, and are only aware of churches as the main social support network for refugees on ARVS.

Furthermore, the hospital has not instituted health practices that are culturally and linguistically appropriate for refugees. There are only two interpreters at the hospital, one English-speaking and one Xhosa-speaking, who are supposed to cater for the diverse languages spoken amongst the host population, but no interpreters in any of the languages spoken by refugees. The doctor in charge insisted that there was no need for French interpreters, as the refugees usually

managed to find a friend or family member to help in that area; and the hospital had not up until then experienced problems with interpretation. However, the counsellors contradicted the doctor, explaining that they did see a need for interpreters for the refugee community. With only four refugees on their counselling list, however, the counsellors do not really comprehend the refugees' situations, because of communication barriers. Three of the four refugees on their records are accompanied by friends who help them to interpret, while the fourth refugee, a woman, comes with her husband who interprets for her. Unfortunately, though, her husband only accompanied her the first time; at the subsequent meetings, it was thus impossible for the counsellors to do any counselling. Consequently, the counsellors do feel there is a real need for an interpreter, but no one has raised the issue for managerial consideration yet.

The situation at Victoria confirms reports from the UNHCR that refugees' access to healthcare at public hospitals is being hampered by language barriers. The French-speaking refugee patients visiting Victoria Hospital thus face problems communicating with healthcare workers. As the level of access to public health care can be inhibited by the lack of qualified interpreters, it is clearly an important issue. The presence of friends and family during counselling sessions can furthermore cause difficulties with confidentiality, especially in view of the complexities related to HIV/AIDS. Women's health problems similarly require particularly sensitive handling, which is hampered when family members or friends have to act as interpreters. The presence of such unsuitable interpreters can affect the level of access to healthcare by women. Women's health can be affected not only by the gender of the doctor, but also by the dynamics surrounding the interpreter (BMA 2005). It is exactly in response to such situations that the UNIADS BPGS were drafted to promote deliberate efforts by host countries to provide services in the language and culture that is friendly to refugees. There are no deliberate policy guidelines in place at Victoria Hospital to make interpreters available for refugees. This suggests that the absence of the interpreter has not been prioritised as a human resource need.

Moreover, the absence of French interpreters at public hospitals where a significant number of patients are French-speaking can in fact be interpreted as a form of discrimination and abuse of the right to an interpreter. A language clause exists in South Africa that is supported by the Bill of Rights, which recognises language as a basic human right. The Constitution goes further to prohibit discrimination against anyone on the grounds of language (Alexander 2002). Supporting the Constitution in this regard is the Refugee Act, which states that a refugee is entitled to enjoy every right as a citizen, except the right to vote or form political parties. It would

be plausible to assume that, within the human rights lenses, refugees do have the right to a professional interpreter at public hospitals.

Lastly, the UNAIDS BPGS recommends the use of data capturing methods for refugees to enable effective management of the HIV/AIDS disease in that population group, bearing in mind the unique characteristics of this group. There are two systems of managing data at hospitals. The first is evident when patients first register at reception, where information is collected on the patient's address, income, date of birth, number of dependents, and church affiliation. For refugees, this type of information can be used to determine the trends of HIV/AIDS rates amongst that population group; it should furthermore show the cultural appropriateness (or not) of HIV/AIDS responses to such patients, and it should help with follow-ups on ARV adherence.

However, in South Africa, the prevalence rates amongst refugees are not known. The hospital does not segregate this type of information as such. The data that has been collected can therefore not inform the analysis and design of culturally appropriate programs. The doctor in charge of the HIV/AIDS program dismissed the need for programs that culturally target refugees as irrelevant, because he claims that refugees understand perfectly the medical approach used by the hospital.

4.4 The Trends Emerging From Both Case Studies

Table 3 below describes the trends that emerged from both of these case studies. A specific comparison is made, firstly, with regard to the UNAIDS BPGS, secondly, with regard to the factors that affect implementation, and thirdly with regard to the factors that affect the absorption of BPGS into policy statements and implementation. The factors representing the UNAIDS guidelines are summarised as the 'special targeting of refugees and the consideration of language and cultural appropriateness', whereas factors affecting implementation are those referring to 'managerial willingness to absorb UNAIDS BPGS, the institutional and human capacity and national and institutional refugee policies and guidelines.' Lastly, the factors representing the institutional absorptive capacity of BPGS are 'the institutional awareness of the BPGS, the institutional relationships with the custodians of the BPGS and the adequacy of funding to support the absorption of the BPGS.'

Table 3: Trends from the case studies in relation to BPGS, institutional and absorptive capacity

Themes	Factors of comparison	Hospital	PPASA
UNAIDS BPGS	Special targeting of refugees	No	Yes
	Consideration of language and cultural appropriateness	No	Yes
Absorptive capacity	Partnerships with other stakeholders	No	Yes
	Relationship with UNHCR	No	Yes
	Awareness of the UNAIDS BPGS	No	Yes
	Absorption of UNAIDS BPGS	No	Yes
	Adequate funding for refugee programs	No	Yes
Institutional capacity	Necessary refugee management guidelines and policies	No	Yes
	Capacity of institutional human resources to absorb UNAIDS BPGS	No	Yes
	Managerial willingness to absorb UNAIDS BPGS	No	Yes

Table 3 above indicates that, at PPASA, the HIV/AIDS practice is based on the UNAIDS BPGS. Not only is the organisation aware of the BPGS, but it has also adopted the principles of these guidelines. The trends further point to the successful implementation of the refugee HIV/AIDS

initiative in the inclusion of refugees in the national HIV/AIDS strategy, which has made it possible for a budget to be set aside for the refugees' HIV/AIDS initiative and for funding from the UNHCR for this purpose. The close relationship between PPASA and UNHCR is the main reason why PPASA was in possession of the BPGS.

In contrast, the findings at Victoria Hospital revealed that refugees are not particularly targeted nor are there any interventions especially placed to enhance refugee access to health care. The hospital treatment practice is based on the World Health Organisation HIV/AIDS protocol procedure, which is standardised to apply to everyone, regardless of race, gender, culture or national identity. Moreover, the hospital is not aware of the UNAIDS BPGS.

4.5 Discussion

This study investigates the practice of HIV/AIDS programs in Cape Town, particularly as they pertain to refugees, within the framework of the UNAIDS BPGS. It also questions the possible reasons why the BPGS have not been fully absorbed and how this has affected the quality of the treatment programs. The discussion of the two case studies in relation to the UNAIDS BPGS is thus placed within the framework of the national policy, its implementation and the absorptive capacities of the two institutions. Lowi's model (1963) is used in analysing the implementation at PPASA and Victoria Hospital, while Gertler's model (2001) of the adoption of best practices is used to explain the extent to which the UNAIDS BPGS have been adopted. Before we can discuss issues of implementation, however, it is important to look at the broader policy issues that have shaped the nature of implementation at an institutional level.

4.5.1 Some Broad National Policy Issues

A policy outcome should not only meet the expectations of a target group, but should also be inclusive of those who will be affected by those particular outcomes. The policy design phase is pivotal in assessing the policy outcomes of a chosen policy, because it is the phase during which operational goals (or objectives) are set, which influence the extent to which implementation meets the intended need. The extent to which the HIV/AIDS policy yields the intended outcomes for refugees is also affected by the extent to which goals, objectives and steps to meeting those goals are clearly stipulated (Hogwood and Peters, 1985: 20). This suggests that the failure of policies to address the needs of its beneficiaries effectively can be due to the nature of their

designs, which may include incompatible stated goals, a lack of clarity, or steps in the stated goals that cannot be translated into tangible objectives. Similarly, with the HIV/AIDS policy, the setting of operational goals influences the extent to which implementation meets the intended need. The UNAIDS' experience and also the experience of the European strategies with regard to the implementation of HIV/AIDS policies confirm that refugee-related HIV/AIDS issues can only be attended to if they are incorporated into national policy, with clear steps showing the specific objectives to be attained (AIDS Infotheque 2000).

In South Africa, the HIV/AIDS strategy fails to set out the steps leading to the achievement of refugee health rights as set out in the Constitution. There are, for instance, no strategic steps that oblige Victoria Hospital to develop its own refugee treatment policy for or to focus on the health rights of refugees and asylum seekers. The results of the gaps in policy are manifested at Victoria Hospital, where there is no single guideline governing the treatment of refugees. Another objective whose steps have not been determined properly concerns the surveillance and research function which thus far lacks the mechanisms to collect surveillance data on refugees that would be fundamental to planning for this population group. Victoria Hospital does not have any guidelines of its own nor any from national government on the management of surveillance data with regard to refugees. The weakness in the design of the surveillance and treatment goals, however, can be traced back to the original goal setting levels, where refugees were not mentioned at all. The absence of such steps can be interpreted in many ways. Hogwood and Peters (1985: 20) suggest that policies may sometimes be a political façade that are not intended to produce any tangible outcomes. After all, refugees are not a first priority of the national government, and policies that say something about them (even if only very little) are better than nothing at all. It is clear from this research, that there is an absence of planned substantive policy outcomes in the HIV/AIDS strategy; it may even be suggested that these policy statements are merely a political response rather than expressing an intention to do something constructive.

Moreover the HIV/AIDS strategy in South Africa fails to coordinate the different partners in the networks working in the refugee HIV/AIDS field. Such a national strategy is not sustainable if designed in an ad hoc manner without inclusion of all the stakeholders, and thus it calls for a multi-program environment in its design. A more integrated policy environment can have a positive impact on other supporting policies or on beneficiaries and other organizations, and thus needs intensive coordination (Hogwood and Peters 1985: 20). In the delivery of the South African

national HIV/AIDS strategy with regards to refugees, there are many institutional structures, both governmental and non-governmental. Thus policy implementation affecting international populations happens at many different levels: these may be international, national, provincial or district levels (Wissink 2000). The administration of the HIV/AIDS program for refugees should be designed to include all these institutions and their approaches. In Cape Town, there is a clear lack of knowledge of the refugee HIV/AIDS policy in general and of its policy content with regard to the particular practices amongst the partnering institutions at local level, such as the Victoria Hospital. The Centre for the Study of Violence and Reconciliation (CSVSR) report (2003) concluded that, at local government level, as well as for those implementers working directly with refugees, there was a lack of clarity on the translation of the HIV/AIDS policy to practice with regard to refugees (Palmary 2003).

4.5.2 Implementation

The nature of policy implementation in both case studies is discussed in terms of Lowi's model of implementation (1963) (as cited in Wisink & Cloete 2003). Of all the other models, this model best depicts the factors at play in this study, because it takes cognisance of the role of policy standards and objectives and also the role of inter-organisational communication and enforcement activities, factors that are pivotal in the findings of this study. Lowi's model considers seven interrelated variables, namely, the type of policy standards and their relevance, the availability of policy resources, the existing inter-organisational communication, the characteristics of the implementing agencies, the economic, social and political environment, the disposition of the implementers, and the effect of the above on policy implementation.

In Lowi's model, the relevance of policy standards and objectives is recognised as a factor necessary for determining the nature of implementation. The two case studies are guided by very different policy standards, guidelines and objectives in their implementation. At PPASA, the response to refugees with HIV/AIDS is guided by the best practice standards as contained in the UNAIDS BPGS. PPASA thus did not have to reinvent the wheel, so to speak, and go through a lengthy learning process. It has thus adopted an obvious and clear focus on refugees. At Victoria Hospital, however, the standard policy used is the WHO protocol on treatment of HIV/AIDS that targets a general population, and the UNAIDS BPGS are not used at all. The hospital furthermore has no guidelines in place for dealing with refugees, and lacks a clear strategy for an effective response to HIV/AIDS among this population group. Moreover, the national policy on HIV/AIDS

mentions refugees only under the goal of prevention, but not at all under the goals of surveillance or treatment. Thus there is no reference point in the national policy with regard to treatment.

Even more significant than the lack of integrated focus on refugees is the fact that there appear to be clear goals and objectives with regard to migrants in general, such as those of the Maputo corridor, while there are none for refugees. There are also clear steps with regard to other migrants, who are targeted as special population groups who need special attention. Where specific and targeted initiatives have specific outcomes for other migrants, refugees are expected to access the same services as the host population and thus it is assumed that they do not need to be specifically targeted within the policy. A CSVR research concluded that it is the implicit intention of the Refugee Act to encourage refugee groupings simply to assimilate into South African life, thus enabling them to access the same services as any other South African (Palmary 2003). These assumptions are apparent at Victoria Hospital where questions of separate guidelines are regarded as a waste of resources.

Lowi's model of implementation also recognises the role of effective communication between stakeholders and suggests that successful implementation is dependant on those relationships. Communication is necessary for the success of comprehensive HIV/AIDS initiatives, because all the aspects of care, support, prevention and treatment have to be coordinated. In Cape Town, however, the relationship between the CSOs and the hospitals seems to be weak or even non-existent. Whereas PPASA has formed Tutumike - the refugee HIV/AIDS committee, and communicates with the national departments dealing with refugees, the public hospitals and the other projects dealing with refugees, Victoria Hospital has no relationship with UNAIDS or UNHCR, nor with the supporting NGOs or committees in Cape Town. The treatment aspect of the national HIV/AIDS program depends on referrals of patients to supporting stakeholders in communities to offer social and emotional support to patients within their homes. Thus home-based care and support services would be very useful to the hospital in terms of HIV-positive patient referrals. Nonetheless, Doctor Luker and his counsellors at Victoria Hospital are not aware of any potential relationships between the hospital and the CSOs. The hospital staffs only know of churches as the other source of support for refugees on ARVs. This suggests that home-based care and support services are not well developed yet, which explains the current lack of partnerships with care and support organisations. These non-existent relationships between the different stakeholders have also resulted in a lack of awareness of the UNAIDS BPGS, and a lack of follow-up on refugee treatment. At a national level, moreover, the South African initiative

lacks a clear strategy on referral systems (USAID 2001). The role of such coordination has been apparent in those countries where the success of combating HIV/AIDS has been attributed to the significant role of non-governmental organisations and civil society in general (UNAIDS 2001).

Lowi's model and indeed other models also attribute successful implementation to the disposition of the relevant organisations. PPASA's attitude toward HIV/AIDS prevention is such that they have been working in the area of prevention for many years and have acquired both the capacity and the expertise to implement an effective refugee program. The program also draws on many other resources, illustrating an integrated and successful refugee-targeted HIV/AIDS response.

Victoria Hospital, in contrast, regards itself as a public hospital with a host population focus, and with limited human resources and budgetary capacity. As a result, the Hospital holds the view that catering for refugees as a special group will place too great a strain on their resources. This lack of capacity has affected the appropriateness of the refugee HIV/AIDS health service offered by the hospital. Although budgetary constraints have no doubt inhibited the replacement of an interpreter, a pervasive apathy towards refugee needs has also been a major contributor to the continued absence of an interpreter; this conclusion is supported by the allocation of the budget for interpreters for the local languages, which includes Xhosa and English interpreters. The counsellors confirmed that the absence of French interpreters is indeed a product of a lack of management commitment, although the doctor in charge did not perceive language to be a serious problem.

Related to the absence of a linguistically appropriate language is the absence of culturally appropriate health care. Taking a cultural approach means considering a population's characteristics, including its lifestyles and beliefs, as essential references to the creation of action plans. This is indispensable, if sex behaviour patterns are to be changed and if the pace of expansion of the pandemic is to be slowed down (UNESCO 2001). Whereas PPASA has made an effort to study the living patterns of the refugees and offers them prevention training that is relevant to their culture, the Victoria Hospital is not interested in their cultural orientation or its effect on their health. Dr. Luker was quick to point out that these refugees understand health issues just as much as the host population does, and denied that there were any differences between them. The situation at Victoria Hospital with regard to this lack of cultural sensitivity is exacerbated by two other factors: the inadequate numbers of doctors and supporting staff and the perceived lack of a need for that type of focus. At Victoria Hospital, the HIV/AIDS response unit

is under-resourced due to shortage of qualified staff, with doctors being too few and therefore unable to deal with the social aspects of the disease. The UNESCO cultural report (UNESCO 2001) concluded that capacity constraints can also be the reason for the perception of culture as an obstacle to health care and that it is common for organisations with limited budgets or technical resources to ignore social and cultural aspects of HIV/AIDS. This is clearly visible at Victoria Hospital, where the doctor in charge of the HIV/AIDS held the view that taking culture into consideration when offering treatment was adding an unnecessary administrative responsibility.

The models of Lowi, Berman, Smith and many others discuss the role of policy implementers in determining the success of a policy. At Victoria Hospital, Dr. Luker was adamant that the refugees did not warrant the need for an interpreter and that the use of friends was sufficient for their translation needs. Although the counsellors were aware that this need existed, they blamed the absence of an interpreter on the nature of the current management of the hospital. Thus management is seen to have a fundamental role in the implementation of the HIV/AIDS treatment program.

Lowi also attributes the success of implementation to the role of institutional capacity and resources, which have affected the extent to which the refugees' relationships with their health workers can be formed at the hospital. The counsellors, who are unqualified, too few in number and only employed part-time, can only provide basic counselling services at the hospital. This situation can be improved by employing more qualified members of staff. There is, however, both a shortage of qualified staff on the market and a limited budget to employ extra staff. Added to this is their lack of awareness and indeed skills in the medical, social and cultural issues faced by refugees with HIV/AIDS. These skills could be increased through training. In fact, the UNAIDS BPGS propose training for implementers and decision makers with regard to the cultural issues of marginalized groups. At Victoria Hospital, some ad-hoc training was indeed done, but the only recognisable output was the acceptance of refugee IDs as valid documents when presented at reception. More consolidated training would be needed to effect more profound changes. Good examples of this training can be seen in countries like England, where training covers awareness of asylum seekers' health needs and support services as part of the ongoing in-house sessions for medical workers (Chan 1999). Other factors that affect the nature of programs in the two cases can be explained within the frameworks of absorptive capacity models.

In terms of the BPGS, adoption depends on the organisation's absorptive capacity. In the corporate environment, absorptive capacity is the ability of an organisation to recognize and use

new information, resulting in higher competitiveness (Sinad & Rice 2001). In this study, the absorptive capacity that is relevant to the corporate environment is relevant for PPASA, a development agency. PPASA is in possession of the UNAIDS BPGS by virtue of them being implementers for the UNHCR. PPASA is not only required to know the BPGS, but is also expected to design its programs according to the guidelines – their absorptive capacity is therefore enhanced. Victoria Hospital is not aware of the UNAIDS BPGS, which has lowered their absorptive capacity with regard to the BPGS.

In contrast to the corporate environment, absorptive capacity in public management is enhanced by among other elements, the right policy environment, adequate support from leadership, involvement of stakeholders and adequate funding (Gertler 2001). This study finds both the Gertler (2001) and the Rice and Sinad (2001) models to be limited in their assumptions that absorptive capacities are mutually exclusive between corporate and non-corporate environments. The nature of the programs at PPASA demonstrates that the two models each contribute to an understanding of factors necessary for complete absorptive capacity. The Rice and Sinad model proposes the prerequisite factor (ability to recognise new information) necessary for any BPGS to be considered in the first place while the Gertler model describes the supporting factors relevant for completion of absorption. Beyond awareness of the BPGS, PPASA has also had leadership support in the form of finance and advocacy support, which the other supporting institutions, such as Victoria hospital, have not had. Thus the organisation can afford to tailor its activities towards the refugee-targeted HIV/AIDS program and support them adequately. Some efforts of PPASA, such as the placing of interpreters at all health centres visited by refugees, have suffered setbacks, however, due to weaknesses in the relationships with the various stakeholders. The relationship between PPASA and Victoria Hospital has not been clearly articulated and therefore Dr Luker has no obligation to keep an interpreter on site; nor indeed does he have any recollection of the role played by PPASA at his hospital.

The networks theory concludes that effectiveness in delivery of public service depends on both the networks ability to share resources and to communicate well. Victoria Hospital has no relationships with any stakeholders and exists in an environment where it is expected to offer special services to refugees using resources allocated for the HIV/AIDS responses for the general host populations. However, no additional financial or other resources have been allocated to the hospital to increase its capacity to provide this special response. While refugees can be treated, other components of the healthcare provision that are consistent with refugees' rights are not

covered due to a lack of capacity. Thus this study finds that the absorptive capacity of an organisation is the ability of the organisation to recognize and use new information but that this also depends on the right policy environment, adequate support from leadership, involvement of stakeholders and adequate funding.

4.6 Conclusion

In conclusion, then, the success of implementation at PPASA can be attributed to the factors discussed by Lowi, as discussed in this chapter as well as by the successful implementation of BPGS. It is clear that PPASA has been successful in absorbing the BPGS, because they have the advantage of accessing global best practices. Moreover, PPASA has the right stakeholder involvement in the form of the UNHCR, which is influential both financially and in advocacy, and thus able to support refugee rights in this country. Added to these factors is the organisation's disposition factor, in terms of which PPASA as an organisation has also had the advantage of years of expertise in HIV/AIDS prevention and the necessary human and structural capacity to orient the organisation towards refugee specific activities.

A very different set of factors apply to the Victoria Hospital. The hospital's HIV/AIDS unit has never heard of the BPGS and thus lacks refugee focused guidelines. It is not adequately resourced financially, it is incapacitated by inadequate numbers and skills of health workers, and the institution's disposition is such that their focus is on the broader host population and not on refugees. Victoria Hospital also lacks the multi-sectoral communications that are needed to support simultaneous implementation of policy.

CHAPTER FIVE

5.1 Conclusion

This study documented the refugee HIV/AIDS programs currently operating in Cape Town, and compared those practices to the UNAIDS BPGS. It also investigated whether the resources and capacity levels in the participating institutions were adequate to implement HIV/AIDS programs for refugees that adhere to the UNAIDS BPGS. Investigated also were the possible reasons why the health practitioners would or would not adhere to the UNAIDS BPGS. Two program sites were used as case studies in this research – the Victoria hospital and the PPASA. The findings at the Victoria hospital can be generalised to refer to other hospitals in Cape Town and to some extent to South African public hospitals in general. The findings at PPASA however can only be generalised to other refugee HIV/AIDS prevention programs that are also funded by both the UNHCR and the department of health in South Africa.

In answering the main research question, the study found that two types of HIV/AIDS programs exist in Cape Town – one prevention program managed by the non governmental organisation – the PPASA; and the other, a treatment program running at all public ART centres. The PPASA is funded by both the UNHCR and the department of health and its programs are specifically targeted at the refugees in Cape Town and not the general population at large. This study concludes that the refugee HIV/AIDS program at PPASA is in line with the UNAIDS BPGS.

The treatment program on the other hand is managed at all public hospitals that administer the ART program. This program is funded by the national department of health without any supporting funding from the UNHCR for the refugee specific cases. All the centres in Cape Town that run the ART program are by law required to administer ART to refugees who possess legal ID cards. The treatment program does not have any interventions specific to refugees. In this research, it was concluded that public hospital's HIV/AIDS treatment programs are devoid of the recommendations of the UNAIDS BPGS for migrants.

This research also set out to understand how the institutional resource capacities in the participating programs influence the adoption of the UNAIDS BPGS and why the health practitioners would not adhere to the BPGS. The research concludes that the same factors that

influence levels of adoption of the BPGS by institutions explain why the health practitioners would or would not adhere to the UNAIDS BPGS. In this research such factors as capacity to access information, the funding capacities, the nature of participating institutions and the support from other social networks available to institutions and their staff have influenced the extents to which the refugee HIV/AIDS programs have absorbed the UNAIDS BPGS.

It was found that the PPASA and its health practitioners have had better access to global best practices than the public hospitals; and therefore have had better chances to absorb the BPGS. The public hospitals however are not influenced by and have no known formal links with the UNHCR at all. Consequently, health practitioners at PPASA are fully aware of the BPGS while the hospitals' health workers exhibit ignorance of the UNAIDS BPGS and therefore have no capacity to practice any of the guidelines.

This research also concluded that the nature of the implementing institutions affects the extents to which the institution and its health practitioners may or may not adhere to the UNAIDS BPGS. In the case of Cape Town, the PPASA has clearly had more capacity to absorb the BPGS than public hospitals because of its years of experience in refugee HIV/AIDS prevention. Also, the PPASA has the size, both locally and internationally, that is necessary to adapt the refugee prevention strategy to local conditions. Victoria Hospital, in contrast, has the health orientation and experience of a health centre for host populations. With one doctor and three untrained counsellors, the hospital has neither the size nor the human resources necessary to enhance adoption of the guidelines. The size of the human resources is not adequate to affect the building of health worker-patient relationships necessary to support refugee access and adherence to treatment.

It was concluded also that funding levels influenced the extents to which these institutions and their health practitioners would adopt the UNAIDS BPGS. The PPASA has funding specific to the refugees' HIV/AIDS program from both the department of health and the UNHCR, which helps target refugee specific programs. The public hospitals however are generally under resourced. Furthermore, they do not have extra resources set aside for refugees, no added resources to enhance programs for refugees, and no guidelines to follow in handling refugees. They receive no support from international organisations like the UNHCR.

This research also was concluded that adoption of the UNAIDS BPGS for refugees would be influenced by more coordinated organization of all stakeholders involved in implementing the HIV/AIDS strategy for refugees. The missing link in implementation was systematic access by all

institutions involved in the social networks that support the non treatment aspects of public health. The public hospitals do not have any recognisable social networks that support refugees beyond the treatment. These networks are a strong and necessary resource to managing adherence to treatment for ART programs. The PPASA on the other hand has relationships with a number of refugee HIV/AIDS groups that implement the different facets of the refugee HIV/AIDS prevention in Cape Town – these are the refugee homes, the capacity building program and the public hospitals. This study thus concludes that while the PPASA has a large enough social network adequate to enhance the absorption of the UNAIDS BPGS, the public hospitals lack similar support systems.

This research also set out to find the nature of policy guides used in the programs. The study concludes that the clearly disparate policy guides between the two programs are responsible for the lack of synergy in the refugee HIV/AIDS initiative in Cape Town. The two HIV/AIDS programs for refugees are guided by completely different policies which result in inconsistencies in focus and objectives. While the PPASA is solely influenced by the UNAIDS BPGS specific for migrants, the Victoria hospital uses the WHO guidelines for administering ART to the general public, which makes no specific recommendations for handling of refugees at all. There is no separate guide specific to refugees at the hospital.

5.2 Policy Recommendations

- a) The national HIV/AIDS strategic plan in South Africa should go beyond the mere mentioning of refugees, and should make the policy operational, by clearly setting out its goals and objectives. Policy development should show attainable goals, which can be monitored across the partnering sectors. Strategic plans and goals would allow for targets to be set, and for proper measurement and forecasting of the response, thereby increasing the extent to which resource capacity is targeted at real needs.
- b) There should be both mainstreaming of HIV/AIDS strategies in all the sectors affecting refugees and integration of the policy within all strategic partnerships. This would allow for a holistic and multi-sectoral view of the disease, making possible a more coordinated policy and budgeting across departments.
- c) The policy should also take into consideration that refugees are a particularly vulnerable population group, as much as it accommodates the difficulties experienced by migrants in the

Maputo corridor. Practical steps should be taken to include propositions such as those from best practices.

- d) The UNHCR and government should ensure that standard guidelines on the provision of health care responses to refugees with HIV/AIDS are made known to all implementing partners. These guidelines would promote strategic planning to alleviate access barriers to healthcare, such as language and culture. These guidelines could be the basis for an integrated approach and could facilitate collective planning and reviews, which would ensure meaningful resource planning and budgetary allocation.
- e) In order for the guidelines to work, there should be good communication between stakeholders. This needs to happen at two levels. Firstly, it must happen at the policy development level, where all strategic partners need to participate in policy development. It should include the refugees as beneficiaries, the implementing hospitals and NGOs. Secondly, the UNHCR and the government should coordinate HIV/AIDS activities at provincial and district level rather than leaving it to one single non governmental institution to be the main coordinator of the initiative, whose focus is biased towards fulfilling its own operational objective, namely prevention.
- f) The UNHCR and the South African government need to recognize another large organization specializing in the care and support of refugees, for instance the organisation known as Catholic Welfare and Development, which carries out interventions for refugees. CWD could complement PPASA in the care and support area, where PPASA lacks the necessary expertise, instead of using a multiplicity of organisations that do not specifically target refugees. Big organisations have the capacity, the know-how and also the coverage to implement a successful and dynamic program. The Catholic Welfare and Development organisation has tremendous experience in the care and support area and can provide invaluable input.

5.3.1 Recommendations for Further Research

This research proposes the following areas for further study:

- The extent to which refugees in Cape Town access HIV/AIDS services needs to be further researched. Findings from this research have revealed that language difficulties at the hospital reduce access to healthcare. The actual size of this decrease in healthcare can be further investigated.

- Research to measure actual or close trends of the levels of HIV/AIDS infection would indicate what level the disease has reached, and might form a basis for arguing for a more consolidated approach in programming, which may in turn emphasise the need for home-based care.
- The UNAIDS BPGS contains several good recommendations that would greatly enhance the effectiveness of programs in meeting refugee needs. By highlighting the successful adoption of BPGS at PPASA, this research has shown how the few recommendations of the BPGS changed the way in which these programs were managed. It would be interesting to calculate the relevance of the BPGS both before and after their adoption and implementation.
- A study could be conducted to measure the levels of implementation of the BPGS at the different hospital centres that have received training from PPASA. This would help to assess the levels of improvement in health care. The case of Victoria Hospital can be used to generate generalisable findings of refugee conditions at treatment centres. The research would also help in assessing the reasons why treatment centres deviate from best practices and what can be done about it.

This study was only a description of the existing HIV/AIDS initiatives for refugees, and serves only as a pioneer study in the area of refugees and HIV/AIDS in Cape Town. More explorative and explanatory studies such as the ones suggested here may help build a case that can lead to more comprehensive policy for refugee HIV/AIDS that meets global best practices.

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University of Cape Town

Appendix 1 – Questionnaire

VICTORIA HOSPITAL

PART 1: ASSESSING THE SITUATION

1.1 FUNDING

- a) Is there funding for refugee-specific HIV/AIDS programs?
- b) Who funds these initiatives, and what is your role with those funds?
- c) Are the funds adequate for those initiatives?

1.2 PROGRAMMING

- a) What are the policies being used in the HIV/AIDS initiatives for refugees, why have those particular policies been chosen, and what are their sources?
- b) Are there separate interventions for refugees or are they treated the same as and together with the host population?

1.3 MANAGING DIVERSITY

- a) How do you make local health care facilities more accessible and 'user-friendly' to refugees?
- b) How do you manage health worker/refugee relationships at this hospital?
- c) How do you manage language barriers – do you have interpreters, and if so, how many?
- d) How do you manage the foreign cultural relationships patterns/sexual practices?
- e) Do you have any trained mediators from the refugee communities to help overcome these barriers?

1.4 DATA MANAGEMENT

- a) Please describe the hospital data collection system. What is the process of storing patients' information?
- b) Is there a system for collecting HIV/AIDS prevalence data at this hospital?
- c) Is there a special system for collecting data for refugees that can help in the design of culturally appropriate interventions for this population group?
- d) Does the hospital see the need for a special system for refugees?

1.5 PARTNERSHIPS AND TRAINING

- a) How does the hospital work with other stakeholders that support refugees in the HIV/Aids sector?
- b) Who are those partners that have been identified by the hospital and with whom it works closely?
- c) Has the hospital received any training on best practices with regard to handling refugees?

PART 2: THE BEST PRACTICES

2.1 Are you aware of the UNAIDS best practice guidelines?

a) If you are not aware of these, then:

- i) What informs your program designs?
- ii) How much coordination is there between you and the rest of the refugee HIV/AIDS forum?
- iii) Why would you not be aware of the UNAIDS BPGS?

b) If you are aware, then:

- i) From where did you obtain the UNAIDS BPGS?
- ii) What components of the BPGS have you adopted in your design of programs, and why?

- iii) Which components have you not adopted, and why not?
- iv) What are the available resources and capacity levels, and are they adequate for implementing an HIV/AIDS program for refugees that adheres to the UNAIDS BPGS?

c) If you aware of the guidelines but do not use them:

- i) Which parts of the guidelines would you find useful for your interventions and which would you not find useful?
- ii) What are the key reasons for not adopting these guidelines?
- iii) What is your perception of the BPGS?

2.2 Please explain how the following factors can affect the adoption of BPGS in your organisation.

Presence of factors affecting absorption	Comment
Awareness of BPGS	
Adequate funding for programme	
Support from UNHCR/GOVT	
Necessary policies	
Absorption of BPGS	
Institutional human resources capacity to absorb BPGS	
Managerial willingness to absorb	

Appendix 2 – Questionnaire

PPASA

PART 1 – ASSESSING THE SITUATION

1. FUNDING

- a) Is there funding available for refugee-specific HIV/AIDS programs?
- b) Who funds these initiatives, and what is your role with those funds?
- c) Are the funds adequate for those initiatives?

2. PROGRAMMING

- a) Which area of the comprehensive strategy does your program cover?
- b) What is your program coverage area in the Western Cape?
- c) What are the refugee-specific initiatives you are working on?
- d) How do you define your target group, and what strategies do you employ for your interventions?
- e) Do you have any programs for refugees at border posts?
- f) Do you have any programs for refugees at places frequented by refugees?

3. MANAGING DIVERSITY

- a) How have you designed your programs to cater for language and cultural barriers?
- b) Do refugees participate in the design of these programs and, if so, how?
- c) Do refugees participate in the implementation of these programs and, if so, how?
- d) Are refugee leaders involved in the design and implementation of the programs; what role do the migrant leaders play in providing leadership and why?

- e) What challenges have you experienced in managing these programs?

PART TWO –THE BEST PRACTICES

2.1 Are you aware of the UNAIDS best practice guidelines?

a) If you are not aware of these, then:

- i) What informs your program designs?
- ii) How much coordination is there between you and the rest of the refugee HIV/AIDS forum?
- iii) Why would you not be aware of the UNAIDS BPGS?

b) If you are aware of these, then:

- i) From where did you obtain the UNAIDS BPGS?
- ii) What is your role in distributing these BPGS to other stakeholders?
- iii) What components of the BPGS have you adopted in your design of programs, and why?
- iv) Which components have you not adopted, and why not?
- v) What are the available resources and capacity levels, and are they adequate for implementing an HIV/AIDS program for refugees that adheres to the UNAIDS BPGS?

c) If you are not aware of the guidelines, but do not use them:

- i) Which parts of the guidelines would you find useful for your interventions and which would you not find useful?
- ii) What are the key reasons for not adopting these guidelines?
- iii) What is your perception of the BPGS?

2.2 Please explain how the following factors can affect the adoption of BPGS in your organisation.

Presence of factors affecting absorption	Comment
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