THE SOUTHERN AFRICAN MIGRATION PROGRAMME

MEDICAL XENOPHOBIA: ZIMBABWEAN ACCESS TO HEALTH SERVICES IN SOUTH AFRICA

MIGRATION POLICY SERIES NO. 54

Medical Xenophobia: Zimbabwean Access to Health Services in South Africa

Jonathan Crush and Godfrey Tawodzera

Series Editor:
Prof. Jonathan Crush

Southern African Migration Programme (SAMP)
Open Society Initiative for Southern Africa (OSISA)
2011

Acknowledgements

We would like to thank the Open Society Initiative for Southern Africa (OSISA), the co-publisher of this report, for supporting the research on Zimbabwean migrant access to health and other services in South Africa. Funding for this publication was received from the Canadian IDRC, whose assistance is also gratefully acknowledged. Our thanks to the Zimbabwean students who assisted with the research and the Zimbabwean migrants who graciously consented to be interviewed.

Published by Idasa, 6 Spin Street, Church Square, Cape Town, 8001, and Southern African Research Centre, Queen's University, Canada.

Copyright Southern African Migration Project (SAMP) 2011
ISBN 978-1-920409-63-0
First published 2011
Design by Bronwen Müller

All rights reserved. No part of this publication may be reproduced or transmitted, in any form or by any means, without prior permission from the publishers.
Bound and printed by Logo Print, Cape Town

Contents	Page
Executive Summary	1
Introduction	3
The Right to Health	5
Public Healthcare in Crisis	9
Study Methodology	13
Treatment and Documentation	15
'Difficult' Patients	18
Triaging Zimbabweans	20
Language Barriers	23
Access to Art	26
Conclusions and Recommendations	28
Endnotes	31
Migration Policy Series	38

Executive Summary

Medical xenophobia refers to the negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job. There is considerable evidence that many officials (especially the police, home affairs officials, refugee determination officers and customs agents) bring xenophobic attitudes with them when they come to work. Those in the "helping professions" (such as teachers, social workers and health care professionals) also come into contact with migrants and refugees in the course of their jobs. They have the power to withhold services and they can certainly influence the way in which those services are delivered. This report asks whether and how xenophobia manifests itself within the public institutions that offer health services to citizens and non-citizens. It presents and discusses the question from the perspective and experiences of the foreign patients who try to access the system.

The study extends the findings of earlier research and suggests that the phenomenon of "medical xenophobia" is very real in the contemporary South African public health system. The bad treatment of foreign migrants and refugees in public health facilities cannot all be ascribed to xenophobia, however. Migrants are also caught up in the "crisis of care" that affects every patient in the public health system. The paper concentrates on those forms of ill-treatment that can be attributed to xenophobia and argues that the withholding of treatment from those who need it, and any form of discrimination motivated by hostility to the patient based on their national origins, is a form of xenophobic violence.

The fieldwork for this study was conducted in Cape Town and Johannesburg in August and September 2010. Within each city, three different types of neighbourhood were selected: a middle-income suburb, an informal settlement and a township. The survey focused on Zimbabwean migrants and used two major data collection methods: 100 in-depth interviews and 10 focus group discussions, half in each city. The findings of this survey are therefore indicative rather than representative. What they do show is a troubling disregard on the part of some public health professionals and workers towards the law and their ethical responsibilities to patients. We do not wish to claim that all health workers display the kinds of attitudes and behaviours described in the paper. Some clearly do take their ethical and legal obligations seriously and act with concern and care towards all patients, regardless of where they are from, and despite often trying circumstances. The Southern African Clinicians Society is a major case in point as they played a leading role in promoting equal treatment for all People Living With HIV (PLHIV), both foreign and local. However, by conducting research in six different communities

in two major cities, this report suggests that there is a pattern of medical xenophobia that is not just confined to one or two rogue individuals or institutions.

Medical xenophobia is a fundamental breach of South Africa's Constitution and Bill of Rights, international human rights obligations and various professional codes of ethics governing the treatment of patients. Medical xenophobia manifests itself in several ways in the public health system. Amongst the practices uncovered in this study were the following: first, patients are required to show identity documentation, proof of residence status and evidence of a home address before treatment is provided. Patients who, for one reason or another, do not have such documentation on their persons can be denied treatment. Second, communication difficulties arise when health staff refuse to communicate with patients in a common language or allow the use of translators. Third, treatment is often accompanied by verbal abuse and xenophobic statements and insults. Fourth, non-South African patients often have to wait until all South African patients have been attended to even if they have been waiting longer for treatment. Finally, migrants and refugees have such difficulty accessing anti-retroviral therapy (ART) for HIV in public institutions that many are forced to rely on the NGO sector. All of these manifestations of medical xenophobia are examined at length, with supporting testimony, in this report. The report concludes with a set of recommendations for rooting out xenophobia in the public health system.

INTRODUCTION

Hostility towards migrants and refugees makes South Africa one of the most migrant-unfriendly countries in the world.[1] In May 2008, the country was rocked by violent attacks on the lives and property of Africans from other parts of the continent.[2] Over 60 people died in the violence and over 100,000 migrants were forced out of their homes and communities. President Thabo Mbeki and other leading public figures blamed the violence on fringe criminal elements and denied that xenophobia was a factor.[3] Such a view required a wilful blindness to over a decade of unchecked xenophobia in South Africa that dated back at least to the mid-1990s.[4] In 1994, all foreign citizens in the country were allowed to vote. In the same year, Zimbabweans and Mozambicans in Alexandra, Johannesburg, were attacked by gangs of South Africans in a campaign they called *Buyelekhaya* (Go Home). Other attacks occurred in the years that followed, prompting the South African Human Rights Commission to launch a short-lived "Roll Back Xenophobia" campaign.[5] Mbeki himself even acknowledged in 2001 that xenophobia towards fellow Africans was unacceptable.[6] He also signed into law the Immigration Act of 2002 which committed government to immigration control "performed within the highest applicable standards of human rights protection"; preventing and countering xenophobia; and educating civil society on the rights of foreigners and refugees.[7]

In the 1990s, xenophobia was directed indiscriminately at all foreign migrants (deemed "illegal aliens" in the language of the day).[8] After 2000, as the number of Zimbabweans in South Africa began to increase, they were increasingly singled out by xenophobic state agents and citizens.[9] Overt physical violence became increasingly common. In 2006, for example, two Zimbabweans were killed and Zimbabwean-owned homes and property destroyed in attacks in the informal settlement of Olievenhoutbosch near Pretoria.[10] In March 2008, Zimbabweans were attacked and killed in Choba, Atteridgeville and Diepsloot. Zimbabwean migrants were targeted in many communities in the xenophobic violence of May 2008. More recently, in late 2009, Zimbabweans were driven out of the farming community in De Doorns in the Western Cape.[11] Such attacks are merely the tip of a large iceberg of South African resentment and hostility: 88% of South Africans in a nationally-representative survey in 2006 conducted by SAMP had a negative impression of Zimbabweans (only Somalians at 91% and Nigerians at 89% were more disliked).[12] A 2010 SAMP survey of Zimbabwean migrants who had arrived in South Africa for the first time since 2005, found that 46% had been robbed and 29% had been assaulted.[13] South African media reporting on Zimbabwean migrants is relentlessly negative and blames them for a wide

variety of social and economic ills.[14] Treatment of Zimbabwean workers by South African employers (especially on the farms of Limpopo) is extremely poor.[15]

One of the most common xenophobic stereotypes in South Africa is that public services (including hospitals and clinics) are being 'swamped' by foreign nationals. Two-thirds of South Africans in the 2006 survey felt that foreign migrants "use up" resources and 49% that they bring diseases when they come to South Africa.[16] South Africans also feel that the right to access health services should depend on citizenship and legal status in the country. Over 95% said that citizens should always enjoy the right to social services (including health) and ART (anti-retroviral therapy for HIV and AIDS). However, only 50% felt that legal migrants should enjoy the same right. The figures for refugees and undocumented migrants were even lower (27% and 13% respectively). Two-thirds felt that legal migrants should always have the right to access ART but, again, fewer thought that refugees and undocumented migrants should be eligible (50% and 38% respectively). Fully 43% said that undocumented migrants should always be denied ART. Finally, 61% said they supported a policy of deporting foreign citizens with HIV and AIDS (while only 24% were opposed). Sixty percent favoured a policy of mandatory AIDS tests for refugees.

Xenophobia has become deeply institutionalised within post-apartheid society.[17] There is abundant evidence that state officials (especially the police, home affairs officials, refugee determination officers and customs agents) do not leave their attitudes at home when they come to work. These are the South Africans who probably have most face-to-face contact with foreign migrants and refugees and such interaction does not appear to soften their attitudes. Like "frontier guards" everywhere, they see their mission as making life as uncomfortable as possible for people they believe should not be in the country in the first place.[18] On the other hand, many are not averse to enriching themselves at the expense of vulnerable migrants and refugees. South Africa's "enforcement machinery" has spawned a large corruption industry in which state officials prey on migrants whose main "crime" is to come to South Africa to escape persecution in their home countries or to look for ways of ensuring the survival of their families at home.[19]

Not all employees of the state are in a direct position to exploit vulnerable migrants, asylum-seekers and refugees for personal gain. Indeed, those in the so-called "helping professions" (teachers, social workers and health care professionals) do not play an active role in South Africa's enforcement and immigration control machinery. They do, however, come into contact with migrants and refugees in the course of their jobs. In the absence of official directives to the contrary -- and sometimes

despite such directives -- they do have the power to withhold services and they can also influence the way in which those services are delivered. This report asks how and to what extent, xenophobia manifests itself in the public health system. A comprehensive answer to this question would require research into the attitudes and behaviours of health workers themselves. This report presents and discusses the question from the perspective and experiences of the foreign patients who try to access the system. The study confirms that the phenomenon of "medical xenophobia" is very real in the contemporary South African public health system.[20]

We argue, first, that medical xenophobia is deeply-entrenched despite being a fundamental breach of South Africa's Constitution and Bill of Rights, international human rights obligations and professional codes of ethics. Second, we argue that the bad treatment of Zimbabweans in public health facilities cannot automatically be ascribed to xenophobia. Zimbabweans are also caught up in the "crisis of care" that affects every patient in the public health system. Third, we document those forms of ill-treatment that can be attributed to xenophobia and argue that the withholding of treatment from those who need it, and any form of discrimination motivated by hostility to the patient, is a form of xenophobic violence. Finally, we suggest various remedial measures to root out xenophobia in the public health system.

THE RIGHT TO HEALTH

The international debate over the rights of migrants to access healthcare in countries of destination is a long one. The issue appeared settled in 1990 when the UN adopted the Convention on the Rights of All Migrant Workers and Members of Their Families.[21] Article 28 of the Convention, for example, noted that "migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment." Article 43.1(e) stated, furthermore, that "migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to access to social and health services, provided that the requirements for participation in the respective schemes are met." Article 48.1(c) extended the same rights to members of the families of migrants in the destination country. To date, the Convention has not been ratified by a single major migrant-receiving country around the world including South Africa.[22] However, Articles 28, 43 and 48 of the Convention are perfectly consistent with the South African Constitution.

South Africa is a signatory to the International Bill of Human Rights.[23] Article 13 of the constituent International Convention on Civil and Political Rights and Article 2 of the constituent International Convention on Economic, Social and Cultural Rights protect and guarantee the socio-economic and political liberties of 'aliens' in foreign lands.[24] These include the right of migrants to decent health, education, legal services, and general social security. Article 12 of the same Convention affirms the right of everyone "to the enjoyment of the highest attainable standard of physical and mental health." To fully realize this right, states should create conditions which assure medical service and medical attention for all.

Domestically, Section 27 of the Bill of Rights in the South African Constitution notes that everyone has a right to have access to health care services.[25] This section (unlike most others) is silent on the citizenry of the people upon whom the rights are bestowed, and is commonly interpreted as applying to citizens and non-citizens alike. Furthermore, Article 27 (g) of the Refugees Act (130 of 1998) makes it abundantly clear that refugees in South Africa are to be given the same rights of access as everyone else in the country: "Refugees as well as refugee children are entitled to the same basic health services … which the inhabitants of the republic receive from time to time."[26]

As London notes, there are three ways in which responsibility falls on South African health professionals to realize the human rights codes to which the state is committed: (a) health professionals can become the instruments through which the state meets or violates the right to health; (b) some human rights obligations apply amongst individuals (e.g. the obligation on individuals not to discriminate amongst people on the basis of race, gender, sexual orientation or other factors) and (c) human rights may be viewed as an essential part of professional conduct.[27] While (a) and (b) carry the possibility of legal sanction, (c) depends on professional self-regulation and ethical compliance. Using ethical frameworks alone to guide health professionals generally has limited effect and the strength of ethical guidelines depends on the capacity of the institutional framework for professional regulation. Nevertheless, it is important to lay out what these ethical codes and guidelines actually consist of in South Africa.

South African health professionals are subject to various state-endorsed codes of professional ethical conduct regarding their responsibilities to patients. Article 2.1 of the 1999 National Patients Rights Charter of the South African National Department of Health asserts, for example, that "everyone has a right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal, as well as protection from all forms of environmental danger, such as pollution, ecological

degradation or infection."[28] Article 2.3 further notes that everyone has the right to access health care services that include timely emergency care (at any health care facility that is open, regardless of ability to pay); treatment and rehabilitation; provision for special needs (in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV or AIDS patients); counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS and palliative care that is affordable and effective in cases of incurable or terminal illness. Patients also have a right to "a positive disposition displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance."[29] These rights are clearly specified as being for "everyone," not just South Africans.

In 2006, the statutory Health Professions Council of South Africa (HPCSA) formulated a set of rules regarding the conduct of all health professionals. Section 27(A) notes that health care practitioners should at all times:

- Act in the best interests of their patients;
- Respect patient confidentiality, privacy, choices and dignity;
- Maintain the highest standards of personal conduct and integrity; and
- Provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others.[30]

In addition, they are enjoined to "maintain proper and effective communication" with patients.

The South African Medical Association's "Statement of Doctors and Patients Rights and Responsibilities" states that patients have the right "not to be unfairly discriminated against directly or indirectly on the basis of their race, origin, gender, or any other ground. Patients have the right to be free from harassment."[31] Finally, Article 3 of the South African Nursing Council's Code of Conduct directs nurses and midwives to:

- Act in such a manner as to protect the health status, interest and well-being of the client, especially clients vulnerable due to health status, age, disability or social position;
- Ensure the safety of the client by measures such as correct identification, safe application of diagnostic and therapeutic interventions, appropriate monitoring of the client's condition and accurate and complete recording of care and observations, timeous and appropriate referral of the clients, consultation and/or giving

assistance in an emergency situation;
- Recognize and respect the uniqueness and dignity of each client irrespective of ethnic origin, religious beliefs, personal attributes, nature of the health problems or any other factor;
- Avoid any abuse of the privileged relationship with clients and of the privileged access allowed to their person, property, residence or workplace. Respect confidential information obtained in the course of professional practice and refrain from disclosing such information without the consent of the client or an authorized person;
- Deliver equitable care and use products according to the need of patients, not allowing the receipt of gifts, financial or otherwise, from clients or any other party to influence care decisions;
- Work in an open, gender and culture sensitive manner with clients, foster their independence and recognize and respect their involvement in the planning and delivery of care.[32]

In mid-2007, the Southern African HIV Clinicians Society issued a set of clinical guidelines specifically on the access of "displaced populations" to antitretroviral therapy.[33] The guidelines begin by stating that "health workers who treat displaced persons are guided by the same principles that govern the treatment of any patient before them, irrespective of nationality or ethnic origin, which includes an intrinsic respect for human life and an oath to act in the patient's best interests when providing medical care." The guidelines further state that the role of health workers is "to act, within a legal framework, as advocates for access to health care, and not to restrict or ration care" and to treat patients in a manner that serve's the patient's best interests. Consistent with these principles, the guidelines assert that anyone in need of ART should have the right to access it without hindrance or interference from the health profession.

In early 2006, the National Department of Health issued a statement that patients did not need to be in possession of a South African ID in order to access ART.[34] In 2007, the Department went a step further and issued a directive that refugees and asylum seekers with or without a permit could access basic health care and should be assessed according to the current means test.[35] ART services were to be provided free of charge. The directive fell short of the constitutional imperative to allow all in the country access to healthcare, but it did reaffirm Article 27(g) of the Refugees Act. The Gauteng Provincial Department of Health went one step further in 2008, issuing a directive to its hospitals and clinics that "no patient should be denied access to any area care service, including access to antiretrovirals, irrespective of whether they have a South African identification document or not."[36]

A statement by health advocacy NGOs to the South African National AIDS Council (SANAC) in mid-2008 suggested that all of these constitutional, legal, ethical and normative guidelines were being widely flouted in public hospitals and clinics: "(They) appear to be unilaterally creating policies which deny refugees access to health care services, violate existing legal and human rights obligations, and undermine the objectives of the NSP (National Strategic Plan)."[37] More recently, Human Rights Watch maintained that "South African health care professionals are endangering the health of the country's large foreign population by routinely denying health care and treatment to thousands of asylum seekers, refugees, and migrants."[38]

Public Healthcare in Crisis

South Africa's two tier health system delivers world-class care to those who can afford to pay steep health insurance premiums and a grossly inadequate standard of care to the majority of the population who cannot.[39] The public health system is heavily overburdened and in an advanced state of disrepair in large parts of the country. Many facilities are understaffed and health professionals are highly stressed and overworked. Few South Africans are happy with the quality of the care that they receive at public health institutions. The burden of delivering health care to all has been worsened by staff shortages and increased workloads resulting from the "brain drain" to industrialized countries and the devastation of the HIV and AIDS pandemic.[40] Some South Africans blame this state of affairs on what they perceive to be the millions of foreign migrants who not only bring disease to the country but place an intolerable burden on the health system. They would prefer all foreign migrants go home but, if not, they certainly do not feel that migrants (and even refugees) should be entitled to the same level of healthcare as themselves.

A primary challenge in assessing the reasons for the ill-treatment of foreign patients is the assumption (often held by migrants themselves) that when they are denied services or treated badly by health workers, it is because they are foreign. Here, for example, are two descriptions of extremely callous treatment experienced by Zimbabwean migrants at South African hospitals:

> I have a problem with my legs….they are always itching and getting swollen such that sometimes I cannot even walk. The doctor that attended me at the government hospital says that I am diabetic, but I do not think that I am. He did not even conduct tests, but just put me on that medication which I have taken for some time without any changes. He

> does not have time to listen to what I try telling him, he does not even allow me to really say how I feel…..this is not diabetes, no, no. The problem actually started after I had an accident some 4 years ago, so I think it is related to that accident. But who do I tell? Two, three minutes and I am shoved out of the consultation room. They can't do that to South Africans because locals insist on their rights and we cannot.[41]

> I have personally been treated badly at one of the larger referral hospitals in the city. I fell from a ladder while trimming a hedge and developed a deep gash on my shoulder so I was referred from a clinic to the hospital for minor surgery. Before the doctor came, a middle-aged nurse had to wash the wound with disinfectant. But she kept jabbing at the wound with some kind of calipers and cotton. I told her that it was painful, but she ignored me and even became rougher. It was only when the doctor came in that she became gentle….Imagine at 37 years, I was almost crying, but she did not seem to care.[42]

Such treatment is clearly unacceptable and ignores patient welfare but is it necessarily xenophobic? Both of the migrants felt they were treated this way because they were not South Africans. But one would probably not have to look too far to find South Africans with similar stories of poor treatment at the hands of health workers. There is abundant evidence that many patients (not just foreign migrants) receive substandard treatment at South Africa's overcrowded hospitals.[43]

One study cites numerous examples of patient abuse in obstetrics wards including "clinical neglect, verbal and physical abuse from nursing staff which was at times reactive, and at others, ritualised, in nature."[44] Low-income patients in another study "strongly criticised staff in public clinics and PDS practices for being rude and lacking respect for their clients."[45] Patients complained about the "bullying tactics" of health workers and their lack of care for patients. Another study argues that South African nurses distinguish between "good patients" and "difficult patients" and treat them very differently.[46] Good patients are seen as passive, quiet and do not ask questions. Difficult patients are rude, aggressive, complain and are uncooperative. Finally, both nurses and patients "feel frustrated, disappointed, resentful and even enraged in a context where they cannot be in control and cannot care or be cared for."[47]

Part of the explanation for the behaviour of health workers probably lies in the deep frustration that many have with their jobs. Various studies have shown that there is widespread dissatisfaction with working

conditions amongst South African health professionals.[48] A survey conducted by SAMP in 2007 found that over a quarter of health professionals were dissatisfied/very dissatisfied with their employment on seventeen of the nineteen measures used.[49] On three of the measures (workload, prospects for professional advancement and ability to find the right job), over 40% were dissatisfied. On another three (taxation, fringe benefits and remuneration), over 50% were dissatisfied. On only two of the nineteen measures (appropriateness of training for the job and collegial relations) were high rates of satisfaction recorded. Nursing staff in public hospitals were amongst the most dissatisfied of all health workers.

The health professions in South Africa are highly stressful, demanding and unforgiving. Previous studies have identified the high degree of personal vulnerability and insecurity felt by health professionals in the workplace. One study, for example, found that 34% of public sector health workers and 24% of all workers were "very worried" about high levels of workplace violence.[50] It also found that 17% of workers in the public sector had been physically attacked in the previous 12 months. In the previous year, 52% of all workers said they had been subject to verbal abuse, 23% to racial harassment, 24% to bullying and 5% to sexual harassment.[51] Health professionals in South Africa also face unusual personal health risks from treating patients with infectious disease such as HIV, TB and Hepatitis B. Frontline health care workers are estimated to be six times more likely to get drug-resistant TB than the general population.[52] The impacts on health professionals include heavier workloads, the physical and psychosocial stress of dealing with terminally-ill patients and increased occupational exposure, particularly in provinces with high prevalence.[53] Although the concern about infection is normally out of proportion to the actual risk, the fears are still very real.[54] One study, for example, reports that 46% of nurses were afraid they might infect their partners and children because of exposure to HIV at work.[55]

Health professionals in South African public institutions are chronically dissatisfied and sometimes take out their frustrations on their patients. Other reasons for poor treatment of patients include "a complex interplay of concerns including organisational issues, professional insecurities, perceived need to assert 'control' over the environment and sanctioning of the use of coercive and punitive measures to do so, and an underpinning ideology of patient inferiority."[56] Nurses are said to be engaged in a struggle to assert their professional and middle class identity and in the process deploy violence against patients as a means of creating social distance and maintaining identity and power. Violence becomes routinized because there is no accountability and little action is taken by managers and higher levels of the profession against nurses who abuse patients.

Simply because a foreign migrant receives poor or abusive treatment at a health facility, then, we cannot assume it is because they are foreign or that this is evidence of xenophobia. Human Rights Watch maintains, however, that migrants experience specific abuses on top of the 'systemic failures' that affect all patients, compounding their vulnerability: "they are actively discriminated against and they are targets of violence specifically and exclusively because they are non-nationals."[57] If there is clear evidence that a patient is being treated badly or denied treatment because they are foreign, or are denigrated verbally or physically for being non-South African, then we have evidence of medical xenophobia. When South African health workers distinguish between "good" and "difficult" patients they are generally referring to the personality, behaviour and degree of quiescence of the individual involved.[58] However, when the criteria for "difficult" patients includes such markers as language, colour, legal status and national origin, then there is clearly a significant element of xenophobia involved. For one thing, it means that no matter how "well" a foreign patient behaves, they will never be considered a "good patient" by xenophobic health personnel. Or again, if there is evidence that a local patient receives preferential treatment precisely because they are not foreign, then this too can be justifiably interpreted as a response motivated by xenophobic sentiment.

Previous studies have suggested that migrants face a myriad of problems when they try to access government health services in South Africa. Human Rights Watch, for example, argues that there are four major barriers to migrant access to health care: (a) discrimination -- the denial of access to health services on the basis of national origin or legal status; (b) inadequate, inaccurate and misleading information -- the failure of the Department of Health to inform migrants and health workers of the rights of asylum seekers and refugees to obtain basic health care and ART; (c) barriers to emergency care for rape survivors; and (d) extralegal user fees – charging of exorbitant (and sometimes illegal) fees by health workers at facilities.[59] With regard to access to ART, foreign patients are denied treatment for not having South African identity documents; are charged extralegal and prohibitive user fees; are verbally abused by health care workers; and have communication problems due to language differences.[60] In some cases, refugees are denied ART and access to a doctor unless they first pay a large consultation fee.[61] The FMSP's Migration Rights Monitoring Project identified the most important kinds of problems experienced by migrants in accessing health care as (a) language problems (mentioned by 28%); (b) being treated badly by nurses (23%), clerks (14%) and doctors (10%); and (c) being denied treatment because of unacceptable documentation (22%) or being a "foreigner" (21%).[62]

Lawyers for Human Rights lists a whole series of health care irregu-

larities at government hospitals including (a) asylum seekers and refugees being required to pay a large deposit to access medical services; (b) hospital front line staff and their superiors refusing or being unable to recognize asylum seeker permits, refugee permits and refugee identity documents; (c) refusal to treat children of asylum seekers and refugees; (d) refusal of pre-natal and post natal care; and (e) refusal to issue ART to foreign patients regardless of the type of documentation they possess.[63] Insults and public degradation by hospital staff are common.[64] Zimbabwean patients "continue to be rejected, charged exorbitant fees, subjected to long delays or inappropriate treatment, or prematurely discharged, placing health care out of reach of many."[65]

STUDY METHODOLOGY

The fieldwork for this study was conducted in Cape Town and Johannesburg in August and September 2010. Although Zimbabwean migrants are scattered around the country, the majority live in these two cities. Within each city, three different types of neighbourhood were selected. In Cape Town, the three areas were Observatory (a middle-income suburb), Du Noon (an informal settlement) and Masimphumelele (a township). In Johannesburg, the survey was carried out in Johannesburg Central (the inner city), Alexandra (a township) and Orange Farm (an informal settlement).

Sampling migrants in a country like South Africa presents considerable challenges. The last national census in South Africa was in 2001 and the Zimbabwean population has become far more geographically dispersed since then. Migrants also easily blend in with locals, making them more difficult to identify. As a result, it is almost impossible to develop a sampling frame, even at the community level. In order to overcome this challenge, the survey adopted a "snowball" sampling strategy to identify respondents. This involved the use of respondents to identify other respondents through their own networks. The process began by identifying migrants as initial sampling points. Considerable effort was made to ensure that the initial sampling points were of varied backgrounds in terms of age, occupation, gender and legal status. Given the "mixed" nature of Zimbabwean migration to South Africa, the aim was to identify and interview as heterogeneous a sample as possible.

The survey used two major data collection methods: in-depth interviews and focus group discussions. One hundred in-depth interviews were carried out in the two cities: 50 in Cape Town and 50 in Johannesburg. These interviews collected detailed information on access to health and educational services, the challenges migrants face and other issues related to these services. To complement data gathered

through interviews, a total of 10 focus group discussions were conducted, 5 in each city. In Cape Town, the focus group discussions were held in the following areas: one in Observatory and two each in Du Noon and Masimphumelele. In Johannesburg, one focus group discussion was undertaken in Alexandra while two each were conducted in Johannesburg Central and Orange Farm. Each focus group discussion had approximately 10 participants. Besides collecting additional information and opinions, the focus group discussions gave respondents the opportunity to talk about their own experiences and those of other migrants.

For much of the first half of 2010, there were rumours circulating in South Africa that the end of the World Cup would herald the expulsion of foreigners. Most foreigners in the country were very uncertain about the future and felt at increasing risk as the World Cup drew to a close. In some communities, such as Du Noon in Cape Town, sporadic incidents of attacks on foreigners had been reported. Zimbabwean migrants felt particularly insecure as their numbers seemed to make them an easy target. This was the situation that confronted our fieldworkers, particularly in Cape Town. The fact that all of the field researchers were Zimbabwean and spoke the major Zimbabwean languages (Shona and Ndebele) meant that they were in a better position to allay such fears and elicit honest answers.

The findings of the survey are indicative rather than representative. What they do show is a troubling disregard on the part of some public health professionals and workers towards the law and their moral and ethical responsibilities towards patients. We certainly do not wish to claim that all health workers display the kinds of attitudes and behaviours described in the following sections. Some clearly do take their obligations seriously and act with concern and care towards all patients, regardless of where they are from, and despite often trying circumstances. The Southern African Clinicians Society, for example, has played a leading role in promoting equal treatment for all PLHIV, foreign and local. However, by conducting research in six different communities in two major cities, we have sought to move beyond existing studies that tend to focus on one area or community. We suggest that there is sufficient evidence of a pattern of medical xenophobia that is not confined to one or two rogue individuals or institutions.

Treatment and Documentation

The most important obstacle for Zimbabwean migrants trying to access health services in South Africa is the issue of documentation. Zimbabwean migrants carry a wide variety of documents including Zimbabwean passports, temporary and permanent residence permits, short-term visitors and business permits, refugee documents and asylum-seeker permits. Some carry no documentation at all. Constitutionally and ethically, none of this should matter. When a Zimbabwean migrant or refugee is ill and seeks treatment at a government hospital or clinic, they should be treated just like anyone else. But, in practice, it does matter. Hospital clerks do not ask for identification to verify the name or address of the patient; they do so to assess national origins, legal status and eligibility for treatment.

The majority of study respondents said that it is very difficult to get any kind of treatment in South Africa without first producing identity documents such as passports. Private sector facilities generally do not ask for such documentation, being generally far more interested in a patient's ability to pay. Those who cannot produce evidence of their legal right to be in South Africa are regularly refused treatment or turned away from government hospitals and clinics, no matter how sick they are. Even those who have asylum or refugee documentation face difficulties. When a person lodges a refugee claim, asylum seeker permits are issued for short periods of time – three months in the case of Zimbabweans – and have to be continuously renewed at the place of original issue. Some migrants in Cape Town indicated that they have to travel to Johannesburg or Port Elizabeth to renew their permits. In many cases they let their permits lapse because of the prohibitive cost of travelling. One respondent decribed what happened when he tried to get treatment at a local clinic after his asylum papers had expired:

> One time, last year, I developed a severe cough from the dust and dirt that I was exposed to in the construction industry. So I went to the clinic hoping to get some medicine. I had my asylum permit, but it had expired and they refused to treat me. I did not have the money to go to Port Elizabeth to renew it and I told them so. They told me that it was not their problem. I had to get back home without being treated. I eventually sold my cell phone so that I could get some money to buy medicine at a local pharmacy.[66]

Evidence from other respondents suggests that when they are denied treatment, they go back home and continue to suffer from the ailment until it goes away on its own or they succumb. The difficulties of lodging a refugee claim in the first place are many, particularly since there

are few centres in the country that deal with applications for asylum or refugee status. Refugee status would provide more stability and avoid the need for continuous renewal of asylum permits. However, very few South African officials believe that Zimbabweans are "genuine refugees." The processing of refugee claims is very slow and there is an enormous backlog of over 200,000.

Before they are given treatment, Zimbabweans are often asked to provide proof of residence in the form of a consumer bill, a bank statement or other documentation that indicates their residential address. Many migrants are unable to open bank accounts or transact on issues that require paperwork, which means that they are unlikely to have any documentary proof of residence. One focus group participant in Observatory, Cape Town, told of a friend who was denied abortion services at a big hospital in the city because she had no proof of residence. [67] The friend later had the abortion carried out by a traditional healer. Today she suffers from abdominal and cervical complications arising from the abortion. Thus, demands for identification and proof of residence not only reduce Zimbabwean migrants' access to health services in the country, but heighten their vulnerability to alternatives that are sometimes detrimental.

Instead of being places of healing, hospitals and clinics are regarded by many migrants as spaces to fear. Undocumented migrants – who usually confine themselves to their residences and/or workplaces – tend to try and avoid clinics and hospitals since they run the risk of being intercepted by or reported to the police. One Zimbabwean migrant, who works as a night guard at a restaurant in the city, noted how the fear of arrest is a disabling factor limiting freedom of movement and access to health services:

> For the 8 months that I have been working here, I have ventured out into the city about twice. One of the times I did not get very far before I was arrested by the police whom I had to bribe with R80 so I could be released. Now I rarely go out…if I am arrested again I cannot afford to pay them. If I get sick, I get my friend who has papers to buy me tablets at the pharmacy. There is no way that I can get to the clinic without meeting the police.[68]

There are many more such migrants who, if they fall sick, are unlikely to go to a clinic out of fear. Those who do venture out and are arrested by the police experience routine demands for bribes, money that could be spent on food and medicine.

Migrants allege that even if they have valid documents, they can be harassed and/or arrested. Police are known to tear up valid identity

documentation such as asylum permits and then arrest them for being "illegal immigrants." Thus even those in possession of asylum papers are vulnerable and have to be cautious about their movements, including to access medical services. While migrants who fear arrest and deportation may ask friends to buy them medicines at a pharmacy, they can only access non-prescription, over-the-counter drugs. When the condition is more serious and they need an examination by a health practitioner, the migrants tend to suffer at home without proper advice and medication. Although there was a moratorium in place on the arrest and deportation of Zimbabweans at the time of the interviews, the respondents noted that they were still being routinely arrested by the police until they paid bribes to be released.

Another strategy mentioned by migrants fearful of going to a health facility, is to connive with a friend who goes to a clinic on their behalf and pretends to be sick. They are then given medicine which they bring to their sick friend to take:

> Most of us do it all the time…..I have done it more than 10 times when some of my friends are not feeling well. It is not difficult to pretend to be sick….the last time I went to the clinic I pretended that I had a running stomach and feeling dizzy for that is what my friend was feeling. I got the medication and brought it to him and by the end of 2 days he was feeling okay.[69]

While this desperate strategy may work for some, it is potentially dangerous for both the sick person and the friend who wants to help. The sick person may be exposed to inappropriate medicine if the friend is unable to mimic being sick and accurately describe the symptoms of the disease. In addition, health staff may decide that the impersonator is not very sick as they do not have a fever and are therefore likely to prescribe weaker dosages or nothing at all. For the friends or relatives trying to help, some medicines need to be administered right at the clinic and they may end up being treated while they are not sick, which in itself may be dangerous. Some respondents told stories of how they were given tablets to take at the clinic and could find no way of refusing, and hence ended up taking the medicine even though they were quite healthy themselves.

Once a migrant passes the identification test and is admitted to hospital or treated on an out-patient basis, the problems do not cease. Foreign migrants are not treated primarily as persons with a sickness or disease or injury that requires treatment. Rather, they are categorised and judged, not on the basis of their health status, but their race, language and national origins. The health provider thus builds into their assessment and treatment a judgement on who the person is – whether they

are South African or not, speak a local language or not, are foreign or not, are wanted or not. In other words, the general xenophobic attitudes common to many South Africans infect the thoughts, speech patterns, responses and behaviours of health providers in a variety of ways. To act this way to fellow Africans on the street is bad enough; to verbally and physically abuse sick people who need help is highly unethical.

'Difficult' Patients

How, then, are "difficult" (read Zimbabwean) patients treated? A number of respondents noted a distinct change once the health provider knew that they were Zimbabwean. A pregnant woman in Cape Town, for example, explained how, on a routine check-up, the attitude of the staff changed as soon as they realized that she was a foreigner.

> Everything went well at the time of my arrival at the clinic. Maybe it was because I was pregnant……most people generally respect you when you are pregnant. But when they realized that I was a foreigner everything changed. The nurses started being rude, asking me rude questions like whether I knew who the father of the child was. One even asked me to go back to my country because I was wasting their tax money. They did not check my blood pressure or check to see if the baby was lying in the right posture….all they did was to ask some few questions about how I was feeling and they said everything is fine. That was the last time that I visited that clinic, now I go to a private doctor even though it is expensive.[70]

A 28 year old migrant in Central Johannesburg reported a similar experience:

> I have experienced very bad treatment by nurses several times, but because you are sick, you have to go back again. They do not shout at you or tell you to go away, but their actions tell you just that. Last May I got sick…I had chest pains…so I went to a local clinic. The moment they realized I was a foreigner, they started acting strange, just delaying everything, telling me to wait here and there until I got tired…I think I waited for three hours and I was in pain, so I eventually left without being treated. A friend who came to see me later told me about the MSF clinic and that's where I was eventually treated. There they do not discriminate.[71]

A 26-year old Zimbabwean woman described what happened to her pregnant sister at a hospital in Johannesburg:

> If you are a Zimbabwean and you are having a baby in South Africa you are not treated well by the nurses there in JHB hospital. My sister was one of those people who went through that ordeal. They call you names and tell you "You *Khalanga* [an insulting term], you come here to make babies why don't you go back to your own country and have babies" as if having a child is committing a crime. Even if you get sick you are not treated like a South African will be treated at hospital. They won't give you any medicine. That's what they do in Johannesburg; they are so rough… I always tell my family members that if I get sick please take me home, don't take me to Johannesburg hospital.[72]

According to some respondents, not all non-South Africans are treated equally badly. It matters where you come from. A 42 year old Zimbabwean widow in Masimphumelele, Cape Town, said that it was common knowledge that Zimbabweans were treated worse than other foreign nationals:

> It's the way we were treated that I did not like. We were all speaking in English...you could tell that the nurse was not impressed. She asked us our nationalities and we told them. One of her colleagues asked where Gambia was and they began a conversation with my friend. When I tried to join in, one of them told me to be quiet and I obeyed. We had the same problem as we had been bitten by some kind of fleas in the room we shared, so I expected the treatment to be the same. I was given single pack of tablets while my friend got both tablets and a lotion. I didn't even ask…we just went home and shared the lotion, but I was seething inside.[73]

In Orange Farm, Johannesburg, respondents said that only Mozambicans are treated as rudely and discourteously as Zimbabweans. This may be because Zimbabwean and Mozambican migrants are found in larger numbers in areas like Orange Farm and are therefore likely to constitute a greater proportion of migrants seeking health services.

Most migrants seem to feel that there is little point in complaining to someone in authority at the health facility:

> Some health staff only treat you because they are required by their job to do that, otherwise if it was their decision, they would chase us away. They say that we are finishing

> their medicines….that we are always sick and wanting medicines. There is nowhere to complain because the person to whom you are supposed to report to may also not like us. So we just get whatever treatment we can get and hope that the next time you meet a better nurse.[74]

The respondents noted that negative and hostile attitudes are more prevalent at public than private institutions, at local clinics rather than at larger hospitals and among junior staff rather than their seniors. In addition, most respondents felt that nurses and other junior staff were much more likely than doctors to exhibit negative attitudes towards them.

Triaging Zimbabweans

Triage is a basic principle in the prioritization of patient treatment. Usually, this depends on an initial assessment by a qualified health professional of the seriousness of the patient's presenting condition. Triage assessments are also affected by snap judgements about the credibility of patients and their body language.[75] In the case of migrants in South Africa, another variable appears to enter into the mix: Zimbabweanness. According to respondents, local patients are always given preferential treatment by South African health staff. One man in Alexandra described his experience as follows:

> At times you try to be patient, knowing that you are in other people's country, but it just gets too much. One time I took my brother to the clinic to have his leg checked…he had a swollen vein on his thigh. There were only four people in front of us when we arrived very early in the morning before the clinic had even opened. However it took us almost three and half-hours to be served as some local people just came in and went directly in without queuing. I tried to do the same, but I was roasted right in front of everyone. I complained once and I was told that we would not be served if I tried to be clever. If we had anywhere else to go we could have left…..but we had no money to go to a private doctor.[76]

A 58-year old female Zimbabwean migrant indicated that she had encountered nurses and general members of staff who openly showed their preference for South African over foreign patients. She said that one time she was ordered to go to the back of the queue after she had complained that it was not fair for other patients to just come in and be attended to while they had been waiting in the queue for hours.

Although she later tried to lodge a complaint with senior staff at the clinic, she said she was sure that nothing was done as she saw the supervisor laughing with the offending nurse minutes after she had presented her complaint:

> I just wasted my time….because I saw them laughing together just after I had presented my grievance. I could tell that nothing will be done, and sure enough I haven't been told if anything happened 8 months later.[77]

There were some reported cases of health staff putting patients into two queues, one for locals and the other for non-nationals. All of the locals were attended to first.

A significant number of migrants said that one of the problems they regularly encounter at health centres is that they are never given enough time to explain their illnesses. They allege that as foreigners, they are rushed through explanations and sometimes prescribed medicines before they have finished describing what is bothering them. They feel that this is to get them out of the clinics so that locals can be attended to:

> If you are a foreigner some nurses do not listen to you much. As soon as you start explaining what your problem is, they prescribe medicine before you finish. So if you have two, three or more problems, the chances that you will be treated for all problems are rare. My friend had multiple problems: her heard was aching, her menstrual cycle was giving her problems and she was always feeling tired and all the nurse could prescribe was paracetamol tablets. She tried to ask the nurse if that could solve her other problems but she was just told to move on as it was not only her who needed to be treated. Two days later we had to rush her to a private doctor complaining of dizziness and the doctor said she had lost a lot of blood because of her menstrual problem. He even said the headache and the tiredness was a result of losing blood. Now she is fine, but we had to pay a lot of money…. in fact we had to borrow that money.[78]

Had the patient been given the time to explain and describe her symptoms, it is possible that her medical problem would have been better understood and the ensuing complications avoided. Then there would have been no need to consult a private doctor and pay money that she did not have. Another respondent in Cape Town recounted a harrowing experience when she had to have a tooth removed:

> The whole process left me shaken. I went there thinking that it was going to be like any other simple tooth removal.

> I was injected with a local anesthetic and was asked to wait for 5 minutes on a bench in the corridor for the drug to take effect. After I went back in the treatment room they tried to remove it, but it could not come off. It was painful, I could feel the pain as if there had been no anesthetic and I said so. Although I was given another injection the whole process was just rough…the tooth broke off three times and they did not seem to care. Although they finally removed it, I went through hell and I do not think I will want to have another tooth removed again. Surely they could not have let a South African go through such pain as I did…to make matters worse they were casual about it saying Zimbabwean teeth are too tough for their tools…just imagine.[79]

The joke about Zimbabwean teeth does not prove that the extra pain was inflicted because the patient was foreign. However, at the very least, it displays an awareness of the origins of the patient and a callous disregard for her pain.

Some respondents also felt that the process of getting test results was extremely slow:

> I have only been to the hospital once since I came to South Africa some three years ago. I developed a throat infection, went to the clinic and was referred to the hospital. They did some tests and I was told to come back in two days time to get my results. I went back as advised but was told that my results were not yet out. Since then I have gone back three times without success. My throat is still giving me problems, but I do not know what will be done…whether I will be operated on or not and I have not been given any medication either. It is very frustrating... if I had money I could have gone to a private doctor but I cannot even afford to raise consultation fees.[80]

Other respondents recounted that they had visited hospitals several times for their results, without success:

> I have been to the hospital on more than six occasions and every time I am told that the results of the test are not yet out. It's been over a month now and I am not yet feeling fine so I need those results. But what can I say if they keep telling me to come back…I do not think that I will ever get them. Maybe I should just forget the whole thing and think of other means. But then I also do not have money for the private doctors....I just do not know what to do.[81]

The main culprits seem to be the clerical staff at these health centres who do not take the time to search for the files or do not appear to be bothered. While patient test results are not going to be available instantly, the waiting time should certainly not be unreasonable simply because the patient is not South African.

LANGUAGE BARRIERS

Communication is an important aspect of access to health services the world over. In order for health services to be rendered effectively and efficiently, health staff and patients need to understand each other. Where such communication does not exist or is poor, there is a danger that, at the very least, patients may be given inadequate attention or prescribed wrong treatment. The majority of Zimbabwean migrants indicated that their most common problem with South African health services was language-related. With the exception of Ndebele and Venda, which are also spoken in some parts of Zimbabwe, most South African languages are not easily understood by Zimbabwean migrants. However, this is not simply a case of a communication barrier between speakers of different languages. Such barriers are easily overcome, through the use of a translator or both parties using a common language, if they have one. Neither of these options are palatable to health personnel, which leads to the obvious question of why:

> Communication is the biggest problem. Most of the health personnel speak in their local languages which most of us do not understand. It is especially difficult if you have just arrived in the country and you cannot understand local languages beyond the simple greetings – it really makes things very difficult. It happened to me when I went to the local clinic for the first time and I almost returned without being treated save for the fact that I also met another Zimbabwean woman who had been here for a long time and could speak Zulu. She was like my interpreter that day and I got treatment even though some nurses kept scolding her for trying to interpret on my behalf.[82]

Another respondent indicated that she had a related difficulty in accessing health services when she took her mother for treatment at a local clinic in Cape Town. The nurses at the clinic kept talking to her in Xhosa and Afrikaans even when she had made it clear to them from the outset that she did not understand either language:

> It was a nightmare really. My mother visited me in November last year. She has been suffering from stomach

> problems for a long time, so I took the opportunity of her visit to go with her to the clinic for treatment. I greeted the lady at the reception where we were supposed to get a card in English and she responded in Xhosa. I told her that I did not understand the language and she became furious and started shouting at me, I do not know what she said because I did not understand it, but I could tell it was not good because she was visibly angry. Even the way other patients looked at me told me that she had said something nasty, but I kept my composure and waited. My mother wanted us to go back, but I insisted we wait and eventually we got the card. The nurse who treated her was not better either as most of her communication was in Afrikaans. Because of the way we had been treated thus far, we just kept on nodding as if we understood when in fact we did not. I am only glad that my mother eventually got treated, but it's not something that I would like to experience again.[83]

While communication problems are to be expected when health personnel and patients speak different languages, the use of a common language would minimize the problem. While few South African health personnel are able to speak French (the lingua franca for migrants from Francophone Africa) or Portuguese (which is spoken by Angolan and Mozambican migrants), the case of migrants from Anglophone Africa is different. Most health staff in South Africa can speak a modicum of English, as can migrants from countries such as Zimbabwe.

However, rather than converse in English, health personnel often deliberately make a point of addressing Zimbabwean patients in South Africa's other languages, emphasizing the point that the patients do not speak them and that they therefore do not belong. In some cases, the response from health personnel to migrants speaking English is to dig in and refuse to speak any language other than their own:

> The moment you speak in English, you are in trouble. The nurses pretend they do not understand what you are saying and they leave you and go to treat the next person who speaks their language. It's not as if they cannot speak the language because I have seen and heard some of them speaking in English before. But they just do not want to communicate with you that way. The last time that I went to the local clinic, I addressed the nurse in English and she asked me how long I have been in the country. I told her that I have been here for 2 years and she started scolding me, telling me that I wanted to show them that I was

> learned. She said 'You think you are learned? So why did you come here if you are so clever?' I did not respond for fear of angering her. So she told me to go back to the queue and wait until I was called. She had my card so I had to spend two hours in that queue while people who came after me were treated. I think she just wanted to fix me because I was speaking in English.[84]

Some migrants do try and speak in a local language, however rudimentary their knowledge of that language might be. At times this further infuriates health personnel who take offence at their language being mutilated. One respondent spoke of how he was humiliated for trying to speak in broken Zulu at a local clinic in Alexandra:

> If I was not in pain, I could have returned home without treatment. When I spoke in English they ignored me…… just looked at me as if I was mad or something. So I thought I should speak in Zulu, but I was not good at it as I only knew a few words. The nurse shut me up and said I was speaking inappropriately and asked me how I would feel if my language was spoken like that. I did not answer out of fear, but tried again after a few minutes and failed. He told me that I should learn local languages and I said I will because I thought he meant some other time. To my surprise he called on the next person and ignored me, serving other five people who were behind me. And then another local patient in the queue said something to him and it was only then that I was treated. I think the patient complained that it was not fair because I was visibly in pain. I do not know how long I would have waited if that patient had not interceded on my behalf.[85]

Most migrants are caught between speaking in English or speaking in a broken local language, both of which raises the ire of health staff. Under such circumstances, it is unlikely that migrants are able to effectively communicate their health problems and needs. Some migrants said that the best they can do is to speak as little as possible and hope that the medication that they get is the right one for their ailment. Others indicated that they simply point to the problem area – their stomach, teeth or swollen leg – and hope that the nurses can figure out the rest for themselves.

When patients fail or are barred from communicating their health problems, this is not conducive to the delivery of good health services. Some respondents spoke of situations where they got better treatment for certain diseases because they were able to explain these ailments fully in

local languages. Other conditions were not treated as they were unable to describe all the symptoms using a local language. The fear and anxiety felt by migrants when they try to communicate their health problems is very real and acts as an informal barrier to accessing proper health services.

Access to ART

In 2004, the South African government expanded access to HIV care and took a decision that all health institutions in the country should be ready to receive and assist patients. This represented a dramatic and welcome about-turn after years of official prevarication and dissimulation about HIV.[86] In the first 6 years of the antiretroviral therapy (ART) programme, approximately 900,000 people were started on treatment and by 2012, the government proposes to initiate treatment for another 1.2 million. How many of these patients are migrants and refugees is unknown although there is some evidence that compliance rates with ART is higher amongst non-South Africans.[87] What is certain is that the participation of migrants and refugees in public ART programmes is lower than it could be. This is because migrants still find themselves shut out from and denied ART at public clinics and hospitals.

The most significant study of migrant access to ART conducted to date was in 2008 in inner-city Johannesburg. The study focused on four sites offering ART (two government and two NGO).[88] The study concluded that a "dual healthcare system" had emerged in relation to ART.[89] In theory, and in law, ART was available to migrants and refugees at dispensing government clinics and hospitals. In practice, only 22% of the sub-sample of migrants were receiving ART at government facilities. The rest were accessing ART from the non-governmental facilities. There were two basic reasons for this: first, migrants preferred not to go to public health facilities where they would be asked for identity documents and residence permits. Secondly, non-citizens were being "commonly referred out of the public sector and directly into the NGO sector."[90] In other words, public institutions are implementing their own policies in contravention of existing legislation and, as a result, migrants and refugees are "essentially unable to access treatment in the public sector."[91] Inner-city Johannesburg provides PLHIV with the option to go to NGOs when denied treatment in the public sector but not all non-South African PLHIV around the country have the same opportunity. For them, refusal to treat by public institutions would have fatal consequences.

The present study provided an opportunity to revisit the issue of ART access by Zimbabweans in six different sites across two cities. The research found that the vast majority of migrants were accessing ART

from NGOs rather than public institutions. Most said it was difficult to access these services because they were always told that they did not qualify for ART. A respondent in Johannesburg said that she was tested for HIV at a referral hospital. Although she was counselled, tested and given her results at the hospital, she was not immediately put on anti-retroviral treatment, but rather advised to approach an NGO that would help her:

> I was diagnosed with HIV in September last year after a year or so of being in and out of hospital. My doctor encouraged me to be tested and I got tested after I was counselled. When my results came out positive, I expected to be put on anti-retroviral treatment immediately as I was very weak. But they told me that I had to go to an NGO that could help me as I was not a South African. I do not know if it is a government rule, but that is what they told me and so I went, but I am glad that within a week, the NGO put me on their programme. That is where I have been getting my tablets since then.[92]

A participant in Cape Town noted that by comparison with government hospitals and clinics, it was very much easier to access ART from NGOs:

> Most of the people that I know who are on ARVs get the drugs from NGOs. I think it is easier there…they do not ask a lot of questions and they do not take a long time as the government programmes. The few that I know who access them from the government are not very clear on the process. And they all collect from Groote Schuur…I am not sure whether that's where foreigners are supposed to go or that's where it's easier if you are a foreigner.[93]

This would seem to suggest that even within a single city, different public institutions have different policies. With regard to tuberculosis medication, however, respondents indicated that the process is not very difficult and that one can start treatment as soon as one has been diagnosed. And it seems that the treatment is available at all health centres so that locals and foreigners alike can have easy access.

Conclusions and Recommendations

Migrants in South Africa are routinely denied the healthcare to which they are constitutionally entitled. Most South Africans – and most health workers – probably feel that they should not be entitled to anything. Yet, the South African Bill of Rights is very clear on the issue, as is legislation such as the Refugees Act of 1998. Recent directives from national and provincial governments indicate that they are aware of their responsibilities. However, this study has shown that migrants continue to be denied treatment on the grounds that they are not South African or cannot show the "correct" documentation (correctness being variously and inconsistently defined). It is not the responsibility of public hospitals and clinics to do the government's work of immigration enforcement. It is government's responsibility to make it clear to health facility staff that they are in breach of the law and constitution when they refuse treatment to any patient.

South Africans are generally unhappy with the level and standard of care at their public hospitals and clinics. There is little evidence that foreign migrants find them attractive places either. They go to them when they are genuinely sick or injured and cannot access the private system or NGO sector. The evidence in this study demonstrates that equality of treatment is not an operating principle in many facilities. When they are not denied treatment altogether, migrants are pushed to the back of the line, asked for money that they should not have to pay and generally treated with disdain. On top of that, they have to endure verbal abuse, racist insults and perfunctory treatment. The environment in emergency departments, waiting rooms and wards is unpleasant and often xenophobic. It is not a situation in which people would voluntarily put themselves. They are there because they need assistance.

Medical xenophobia categorises patients by language, appearance and national origin and treats them accordingly. Medical xenophobia rides roughshod over the ethical principles and codes of conduct that are supposed to govern the professional behaviour of health workers and their responsibilities to their patients. Nurses, in particular, seem particularly adept at ignoring their professional responsibilities to patients. But they are not the only ones in the care chain to bring their xenophobia to work. The fact that so many health workers are unhappy and disgruntled with their working conditions is no excuse for treating patients badly. Medical xenophobia is a deep-rooted and pernicious phenomenon which needs to be rooted out of the South African public health system.

More information is certainly needed to assess the pervasiveness of xenophobic attitudes and actions of health workers in public sector

institutions in South Africa. It is important to remember that this paper (and most previous studies on the subject) infer the existence of medical xenophobia from the experiences and perspective of patients. It is important that a complementary effort be made to understand the situation from the perspective of health workers themselves including their attitudes to migrants and refugees, knowledge of migrant patient rights and rationale for their behaviours towards migrants.

The task of rolling back xenophobia in the public health system requires a recognition of the extent and seriousness of the problem and coordinated action by a number of parties:

1. **Government**: National, provincial and local government need to acknowledge that xenophobia is a problem in the health sector and is affecting the quality of health delivery and undermining the professionalism of health providers. Hospitals, clinics and their staff need to be educated on their responsibilities to all patients, regardless of colour, language and national origin. Departments of Health need to make it clear that xenophobic actions, such as those documented in this paper, are unconstitutional, unprofessional and even (in the case of refugees) illegal and that disciplinary action will be taken against individuals who indulge in xenophobic behaviour. Patients should be encouraged to make official complaints against medical institutions and individuals who abuse them any way. At the municipal level, initiatives such as the Mayor's City of Joburg Migrant Advisory Committee and the Johannesburg Migrant Advisory Panel (JMAP) should investigate and counteract medical xenophobia and act to ensure that migrants are able to access the treatment to which they are constitutionally, legally and ethically entitled.
2. **Professional Organizations and Unions**: These organizations need to ensure that their members are fully aware of their professional guidelines and codes of conduct and that they do not discriminate between patients in the performance of their duties. All patients have the right to be treated with care and understanding irrespective of who they are or where they come from. These organizations should take the lead given by the Southern African HIV Clinicians and issue directives and clinical guidelines to their membership about the rights of migrants and refugees and their professional responsibility to treat all patients with humanity and dignity.[94]
3. **Hospitals and Clinics**: Human rights training and workshops should be offered in all facilities which offer medical services to the public. Practising health professionals and administrative staff clearly need to be educated about their responsibilities to all

patients and that any and all forms of xenophobia are unprofessional and unacceptable. Professionals also need to be educated about migration and refugee movements to South Africa, given the prevailing negative stereotypes that persist across the country. The need to communicate with patients means that health workers should be directed to use any common language they may have with a patient and, if that fails, to encourage not resist translation.

4. **Health Worker Training Institutions**: Some South African training institutions appear to offer courses or modules in human rights and professional ethics.[95] It is not clear whether such training extends to alerting trainee professionals about the rights of foreign patients and the problem of xenophobia in the country and its unacceptability in the public health system. All courses on patient rights need to incorporate anti-xenophobia training and alert students to the rights of all patients and the unacceptability of the xenophobic sentiments and actions detailed in this and other research reports.
5. **Civil Society**: NGOs have played a major role to date in bring a much-neglected dimension of xenophobia to the attention of policy-makers, the media and the public. This advocacy role, on behalf of migrants and refugees, must be continued and supported by donors particularly since these groups are often marginalized and discriminated against more broadly and lack a voice with which to articulate their frustrations and concerns about xenophobic treatment at public health institutions. Legal NGOs are encouraged to bring some test cases before the courts to clarify the health rights that non-South African patients are entitled to in the country.[96]
6. **Media**: South African media coverage about Zimbabwean migration to South Africa has been relentlessly negative and stereotypical.[97] The media should adopt a more analytical and even-handed approach to explaining the reasons for Zimbabwean migration to South Africa and the benefits that accrue to both countries from this movement. The media also needs to adopt a "name and shame" campaign against particular public health institutions where there are particularly egregious violations of patient rights.
7. **Donors**: The issue of medical xenophobia is clearly one component of a larger problem in South Africa that is compromising the country's democratic and human rights values. In his 2009 Reconciliation Day address in Pretoria, President Jacob Zuma noted that South Africa "has a long way to go to rid the country of the remaining demons of racism, xenophobia and other social ills" and urged South Africans to "extend their spirit of ubuntu

and reconciliation to foreign nationals living in our country."[98] He said that he was "outraged by the reports of ill-treatment of foreign nationals in some parts of the country" and described such attacks as going "against the spirit and letter or our Constitution and our track record of respecting human rights and promoting dignity." Donors interested in the health sector need to focus resources on innovative anti-xenophobia programming for the health sector that will help ensure that President Zuma's justifiable outrage at the treatment of foreign nationals in South Africa is addressed.

ENDNOTES

1 SAMP, *The Perfect Storm: The Realities of Xenophobia in Contemporary South Africa*. Migration Policy Series No 50, Cape Town, 2009.
2 S. Hassim, T. Kupe and E. Worby, eds., *Go Home or Die Here* (Johannesburg: Wits University Press, 2008); D. Everatt, ed., *South African Civil Society and Xenophobia* (Johannesburg: Strategy & Tactics, 2010); J. Misago, T. Monson, T. Polzer and L. Landau, "May 2008 Violence Against Foreign Nationals in South Africa: Understanding Causes and Evaluating Responses" FMSP Report for CoRMSA, Wits University, Johannesburg, 2010; A. Nyar, "'What Happened?': A Narrative of the May 2008 Xenophobic Violence" Strategy & Tactics Report for Atlantic Philanthropies, 2010.
3 S. Friedman, "One Centre of Power: The African National Congress and the Violence of May, 2008" Strategy & Tactics Report for Atlantic Philanthropies, 2010; T. Polzer and K. Takabvira, "'Just Crime'? Violence, Xenophobia and Crime: Discourse and Practice" *SA Crime Quarterly* 33 (2009): 3-10.
4 J. Crush, "The Dark Side of Democracy: Migration, Xenophobia and Human Rights in South Africa" *International Migration* 38 (2000): 103-33.
5 J. Parsley, "We are Not Treated like People: The Roll Back Xenophobia Campaign in South Africa", *Humanitarian Exchange Magazine* 17 (2002).
6 T. Mbeki, "Statement on Xenophobia" ANC Today 1(18) (2001): 25-31.
7 Preamble to Immigration Act, 13 of 2002
8 Crush, "Dark Side of Democracy"; S. Peberdy, "Imagining Immigration: Inclusive Identities and Exclusive Immigration Policies in Post-1994 South Africa" *Africa Today* 48(2001): 15-34.
9 Human Rights Watch, "'Keep Your Head Down': Unprotected Migrants in South Africa" *Human Rights Watch* 19 (2007); D. Vigneswaran, "Fact or Fiction? Examining Zimbabwean Cross-Border Migration into South Africa" Report for Forced Migration Studies Programme, Wits University, 2007; J. McKnight, "Through the Fear: A Study of Xenophobia in South Africa's Refugee System" *Journal of Identity and Migration Studies* 2 (2008): 18-42; M. Kiwanuka and T. Monsyn, "Zimbabwean Migration into Southern Africa: New Trends and Responses" Report for FMSP, Wits University, 2009; A.

Bloch, "The Right to Rights? Undocumented Migrants from Zimbabwe Living in South Africa" *Sociology* 44 (2010): 233-50; J. Crush and D. Tevera, eds., *Zimbabwe's Exodus: Crisis, Migration Survival* (Cape Town and Ottawa: SAMP and IDRC, 2010); B. Dodson, "Locating Xenophobia: Debate, Discourse, and Everyday Experience in Cape Town, South Africa" *Africa Today* 56 (2010): 2-22; S. Dumba and I. Chirisa, "The Plight of Illegal Migrants in South Africa: A Case Study of Zimbabweans in Soshanguve Extension 4 and 5" *International Journal of Politics and Good Governance* 1 (2010); T. Kamwimbi, K. Banaszak, S. Khan, J., Morgan, A. Nadori and A. Ives , " Violation of Human Rights of Disadvantaged and Vulnerable Refugees – Victims of Xenophobic Attacks in South Africa" *OIDA International Journal of Sustainable Development* 1 (2010): 67-83; N. Kriger, "The Politics of Legal Status for Zimbabweans in South Africa" In J. McGregor and R. Primorac, eds., *Zimbabwe's New Diaspora* (Herndon VA: Berghahn Books, 2010); T. Polzer, "Silence and Fragmentation: South African Responses to Zimbabwean Migration" In Crush and Tevera, *Zimbabwe's Exodus*, pp. 377-99.

10 L. Landau and T. Polzer, "Xenophobic Violence, Business Formation, and Sustainable Livelihoods: Case Studies of Olievenhoutbosch and Motherwell" Report for Forced Migration Studies Program (FMSP), Wits University, 2007.

11 J. Misago, "Violence, Labour and the Displacement of Zimbabweans in De Doorns, Western Cape" FMSP Policy Brief No. 2, Wits University, Johannesburg, 2009.

12 SAMP, *The Perfect Storm*, p. 31.

13 J. Crush, A. Chikanda and G. Tawodzera, "The Form and Future of Zimbabwean Migration to South Africa" Report for SAMP, 2011.

14 A. Mawadza and J. Crush, "Metaphors of Migration: Zimbabwean Migrants in the South African Media" In Crush and Tevera, *Zimbabwe's Exodus*, pp. 363-76; F. Nyamnjoh, "Racism, Ethnicity and the Media in Africa: Reflections Inspired by Studies of Xenophobia in Cameroon and South Africa" *Africa Spectrum* 45(1) (2010): 57-93; M. Smith, "The Media's Coverage of Xenophobia and the Xenophobic Violence Prior to and Including May 2008" Report by Strategy & Tactics for Atlantic Philanthropies, Johannesburg, 2010.

15 N. Kriger and E. George, "Unprotected Migrants: Zimbabweans in South Africa's Limpopo Province" *Human Rights Watch* 18 (2006): 1-52; B. Rutherford, "An Unsettled Belonging: Zimbabwean Farm Workers in Northern South Africa" *Journal of Contemporary African Studies* 26(4) (2008):401-15.

16 SAMP, *The Perfect Storm*.

17 M. Neocosmos, *From "Foreign Natives" to" Native Foreigners": Explaining Xenophobia in Post-Apartheid South Africa* (Dakar: CODESRIA, 2010).

18 R. Cohen, *Frontiers of Identity: The British and the Others* (London: Longman, 1994); J. Klaaren and J. Ramji, "Inside Illegality: Migration Policing in South Africa after Apartheid" *Africa Today* 48(3) (2001): 35-47; R. Amit, "Lost in the Vortex: Irregularities in the Detention and Deportation of Non-Nationals in South Africa" Report for FMSP, Wits University, 2010; L. Landau, "Loving

the Alien? Citizenship, Law, and the Future in South Africa's Demonic Society" *African Affairs* 109 (2010): 213-30.

19 M. Madsen, "Living for Home: Policing Immorality Among Undocumented Migrants in Johannesburg" *African Studies* 63(2) (2004): 173-92; D. Vigneswaran and J. Hornberger, eds., *Beyond 'Good Cop'/'Bad Cop': Understanding Informality and Police Corruption in South Africa* (Johannesburg: Open Society Foundation, 2009); D. Vigneswaran, T. Araia, C. Hoag and X. Tshabalala, "Criminality or Monopoly? Informal Immigration Enforcement in South Africa" *Journal of Southern African Studies* 36 (2010): 465-84.

20 R. Pursell, "Accessing Health Services at Johannesburg's Clinics and Hospitals" In L. Landau, ed., *Forced Migrants in the New Johannesburg: Towards a Local Government Response* (Johannesburg: Foundation for Human Rights, 2006); J. Vearey, "Migration, Access to ART and Survivalist Livelihood Strategies in Johannesburg" *African Journal of AIDS Research* 7 (2008): 361 -74; P. Culbertson, "Xenophobia: The Consequences of Being a Zimbabwean in South Africa" M.A. Thesis, American University, Cairo, 2009; Medicins Sans Frontiers (MSF), "No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa", Johannesburg, 2009; N. Pophiwa, "Healthy Migrants or Health Migrants? Accounting For the Health Care Utilisation Patterns of Zimbabwean Migrants Living in South Africa" M.A. Thesis, Wits University, 2009; R. Shaeffer, *No Healing Here: Violence, Discrimination and Barriers to Health for Migrants in South Africa*. Johannesburg: Human Rights Watch Report, 2009; K. Moyo, "Street Level Bureaucracy: The Interface between Health Personnel and Migrant Patients at Hillbrow Community Health Centre" MA Thesis, University of the Witwatersrand, Johannesburg, 2010; R. Sigsworth, C. Ngwane and A. Pino, "The Gendered Nature of Xenophobia in South Africa" CSVR Research Brief, Braamfontein, 2010; J. Vearey and L. Nunez, "Migration and Health in South Africa: A Review of the Current Situation and Recommendations for Achieving the World Health Assembly Resolution on the Health of Migrants" IOM, Pretoria, 2010.

21 See http://www2.ohchr.org/english/law/cmw.htm

22 R. Cholewinski, P. de Guchteneire and A. Pecoud, eds., *Migration and Human Rights: The United Nations Convention on Migrant Workers' Rights* (Cambridge: Cambridge University Press, 2009); V. Williams, J. Crush and P. Nicholson, "Migrants' Rights After Apartheid: South African Responses to the ICRMW" In Cholewinski et al, *Migration and Human Rights*.

23 http://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf

24 http://www2.ohchr.org/english/law/cescr.htm; http://www2.ohchr.org/english/law/ccpr.htm

25 http://www.info.gov.za/documents/constitution/1996/96cons2.htm

26 http://www.lhr.org.za/sites/lhr.org.za/files/Refugee%20Act%20130%20of%201998.pdf

27 L. London, "What is A Human-Rights Based Approach to Health and Does It Matter?" *Health and Human Rights* 10 (2008): 68.
28 HPCSA, "National Patients Rights Charter" Booklet No 3, Health Professions Council of South Africa, Pretoria, 2008.
29 Ibid.
30 HPCSA, "Ethical and Professional Rules of the Health Professions Council of South Africa as Promulgated in Government Gazette R717/2006" Booklet No 2, Health Professions Council of South Africa, Pretoria, 2008.
31 http://www.samedical.org/index.php?option=com_content&task=view&id=75&Itemid=176
32 See http://www.sanc.co.za/archive/archive2001/newssc105.htm
33 SAHIVSOC, "Clinical Guidelines for Antiretroviral Therapy Management for Displaced Populations: Southern Africa" Southern African HIV Clinicians Society and UNHCR, Johannesburg, 2007.
34 Vearey and Nunez, "Migration and Health in South Africa."
35 J. Vearey and M. Richter, "Challenges to the Successful Implementation of Policy to Protect the Right of Access to Health for all in South Africa" Report from Migrant Health Forum to Gauteng Department of Health, Johannesburg, 2008, p. 10-11.
36 Ibid., p. 12.
37 "Vulnerable Groups: Refugees, Asylum Seekers and Undocumented Persons - The Health Situation of Vulnerable Groups in SA" Joint Submission to the South African National AIDS Council (SANAC), 4 March 2008.
38 http://www.hrw.org/africa/south-africa
39 D. Sanders and M. Chopra, "Key Challenges to Achieving Health for All in an Inequitable Society: The Case of South Africa" *American Journal of Public Health* 96 (2006): 73-8; H. Coovadia, R. Jewkes, P. Barron, D. Sanders and D. McIntyre, "The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges" *The Lancet* 374 (2009): 817-34.
40 S. Benetar, "Health Care Reform and the Crisis of HIV and AIDS in South Africa" *New England Journal of Medicine* 351 (2004): 81-92; S. Cleary, A. Boulle, M. Castillo-riquelme and D. Mcintyre, "The Burden of HIV/AIDS in the Public Health System" *South African Journal of Economics* 76 (2008): S3-S14; J. Crush and W. Pendleton, "Brain Flight: The Exodus of Health Professionals from South Africa" *International Journal of Migration, Health and Social Care* 6(3) (2010): 3-14.
41 Interview No 70, Orange Farm, Johannesburg, 3 September 2010.
42 Interview No 98, Orange Farm, Johannesburg, 3 September 2010.
43 R. Jewkes, "Why do Nurses Abuse Patients? Reflections from South African Obstetric Services" *Social Science & Medicine* 47 (1998): 1781-95; J. Kim and M. Motsei, "Women Enjoy Punishment": Attitudes and Experiences of Gender-Based Violence among PHC Nurses in Rural South Africa" *Social Science & Medicine* 54(2002):1243–54; E. Deetlefs, M. Greeff and M.

Koen, "The Attitudes of Nurses Towards HIV Positive Patients" *Health SA Gesondheid* 8(2) (2003): 23-33; A. Arries and O. Newman, "Outpatients' Experiences of Quality Service Delivery at a Teaching Hospital in Gauteng" *Health SA Gesondheid* 13(1) (2008): 40-54; E. Wouters, C. Heunis, D. van Rensburg and H. Meulemans, "Patient Satisfaction with Antiretroviral Services at Primary Health-Care Facilities in the Free State, South Africa" *BMC Health Services Research* 8 (2008): 210; M. Ayadi, J. de Jager and T. du Plooy, "Do Public Hospitals Respond to the Needs of All Patients in the New South Africa?" In S. Sigué, ed., *Repositioning African Business and Development for the 21st Century* (Kampala: AAADB, 2009), pp. 338-43; M. Breier, A. Wildschut and T. Mgqolozana, *Nursing in a New Era: The Profession and Education of Nurses in South Africa* (Pretoria: HSRC Press, 2009); J. de Jager, A. du Plooy and M. Ayadi, "Delivering Quality Service to In- and Out-Patients in a South African Public Hospital" *African Journal of Business Management* 4(2) (2010): 133-9.

44 Jewkes, "Why Do Nurses Abuse Patients?" p. 1781.

45 L. Gilson, N. Palmer and H. Schneider, "Trust and Health Worker Performance: Exploring a Conceptual Framework Using South African Evidence" *Social Science & Medicine* 61 (2004), p. 1424.

46 D. Khalil, "Nurses' Attitudes Towards 'Difficult' and 'Good' Patients in Eight Public Hospitals" *International Journal of Nursing Practice* 15 (2009): 437–43.

47 L-M. Kruger and C. Schoombee, "The Other Side of Caring: Abuse in a South African Maternity Ward" *Journal of Reproductive and Infant Psychology* 28(2010), p. 84.

48 L. Walker and L. Gilson, "We are Bitter But We Are Satisfied: Nurses as Street Level Bureaucrats in South Africa" *Social Science and Medicine* 59 (2004): 1251–61; B. Erasmus and T. Brevis, "Aspects of the Working Life of Women in the Nursing Profession in South Africa: Survey Results" *Curationis* 28 (2005): 51-60; M. Oosthuizen, "An Analysis of the Factors Contributing to the Emigration of South African Nurses" PhD Thesis, University of South Africa, Pretoria, 2006; H. Kekana, E. Du Rand and N. van Wyk, "Job Satisfaction of Registered Nurses in a Community Hospital in the Limpopo Province in South Africa" *Curationis* 30 (2007): 24-35; C. Selebi and A. Minnaar, "Job satisfaction Among Nurses in a Public Hospital in Gauteng" Curationis 30 (2007): 53-61; M. Engelbrecht, C. Bester, H. Van Den Berg and H. Van Rensburg, "A Study of Predictors and Levels of Burnout: The Case of Professional Nurses in Primary Health Care Facilities in the Free State" South African Journal of Economics 76 (2008): S15-S27; R. Pillay, "Work Satisfaction of Professional Nurses in South Africa: A Comparative Analysis of the Public and Private Sectors" *Human Resources for Health* 7 (2009): 15.

49 Crush and Pendleton, "Brain Flight."

50 S. Steinman, "Workplace Violence in the Health Sector: Country Case Study: South Africa" Joint ILO/WHO/ICN/PSI Programme on Workplace Violence in the Health Sector, Geneva, 2003.

51 Ibid.
52 R. Joshi, A. Reingold, D. Menzies and P. Pai, "Tuberculosis Among Health-Care Workers in Low- and Middle-Income Countries: A Systematic Review" *PLoS Med* 3 (2007); K. Cullinan and S. Smith, "Healthworkers Pay Heavy Price for TB Service" *Health-e* 23 March 2010; D. Pope, S. Atkins, A. DeLuca, H. Hausler, H. Hoosain, D. Celentano and R. Chaisson, "South African TB Nurses' Experiences of Provider-Initiated HIV Counseling and Testing in the Eastern Cape Province: A Qualitative Study" *AIDS Care* 22 (2010): 238-45.
53 C. Bateman, "Can Kwazulu-Natal Hospitals Cope with the HIV AIDS Human Tide?" *South African Medical Journal* 91 (2001): 364-68; E. Hall, "The Challenges HIV/AIDS Poses to Nurses in Their Work Environment" Paper presented to HIV/AIDS in the Workplace Symposium, Wits University, Johannesburg, 2004; O. Shisana, E. Hall, R. Maluleke, J. Chauveau and C. Schwabe, "HIV/AIDS Prevalence among South African Health Workers" *South African Medical Journal* 94 (2004): 846-50; J. Zelnick and M. O'Donnell, "The Impact of the HIV/AIDS Epidemic on Hospital Nurses in Kwazulu Natal, South Africa" *Journal of Public Health Policy* 26 (2005): 163-85; A. van Dyk, "Occupational Stress Experienced by Caregivers Working in the HIV/AIDS Field in South Africa" *African Journal of AIDS Research* 6 (2007): 49-66.
54 A. Minnaar, "HIV/AIDS Issues in the Workplace of Nurses" *Curationis* 28 (2005): 31-8.
55 E. Hall, "The Challenges HIV/AIDS Poses to Nurses in Their Work Environment" Paper presented to HIV/AIDS in the Workplace Symposium, Wits University, Johannesburg, 2004.
56 Jewkes, "Why Do Nurses Abuse Patients?" p. 1781.
57 Shaeffer, *No Healing Here*, p. 5.
58 Khalil, "Nurses' Attitudes Towards 'Difficult' and 'Good' Patients."
59 Shaeffer, *No Healing Here*.
60 Vearey, "Migration, Access to ART and Survivalist Livelihood Strategies in Johannesburg."
61 V. Robinson, "ARVs Elusive for Refugees and Illegal Immigrants" *Inter Press Service News Agency* 24 November 2010.
62 T. Polzer, "Migrant Access to Health Care and Primary Education: Findings from the Migrant Rights Monitoring Project Survey" Forced Migration Studies Programme, Wits University, 2008.
63 Lawyers for Human Rights, "Observations Re Migrants Access to Health Care" In Migrant Health Forum, "Challenges to the Successful Implementation of Policy to Protect the Right of Access to Health for All in South Africa," Report to Gauteng Department of Health, June 2008.
64 R. Sigsworth, C. Ngwane and A. Pino, "The Gendered Nature of Xenophobia in South Africa" CSVR Research Brief, Braamfontein, 2010.
65 Medicins Sans Frontiers (MSF), "No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa," Johannesburg, 2009.
66 Interview No 34, Masimphumelele, Cape Town, 29 August 2010.

67 Participant in Focus Group Discussion, Observatory, Cape Town, 4 September 2010.
68 Interview No 61, Johannesburg Central, 31 August 2010.
69 Participant in Focus Group Discussion, Du Noon, Cape Town, 4 September 2010.
70 Interview No 6, Observatory, Cape Town, 22 August 2010.
71 Interview No 68, Central Johannesburg, 31 August 2010.
72 Crush and Tevera, *Zimbabwe's Exodus*.
73 Participant in Focus Group Discussion, Masimphumelele, Cape Town, 5 September 2010.
74 Participant in Focus Group Discussion, Orange Farm, Johannesburg, 3 September 2010.
75 B. Edwards, "Nurses' Triage Assessments Were Affected by Patients' Behaviours and Stories and their Perceived Credibility" *Evidence Based Nursing* 12(2009): 61.
76 Interview No 81, Alexandra Park, Johannesburg, 1 September 2010.
77 Interview No 32, Du Noon, Cape Town, 23 August 2010.
78 Participant in Focus Group Discussion, Masimphumelele, Cape Town, 5 September 2010
79 Interview No 8, Observatory, Cape Town, 23 August 2010.
80 Interview No 54, Johannesburg Central, Johannesburg, 30 August 2010.
81 Interview No 28, Du Noon, Cape Town, 25 August 2010.
82 Interview No 74, Alexandra Park, Johannesburg, 1 September 2010.
83 Participant in Focus Group Discussion, Du Noon, Cape Town, 4 September 2010.
84 Interview No 12, Du Noon, Cape Town, 25 August 2010.
85 Interview No 67, Alexandra Park, Johannesburg, 1 September 2010.
86 C. Colvin, L. Fairall, S. Lewin, D. Georgeu, M. Zwarenstein, M. Bachmann, K. Uebel and E. Bateman, "Expanding Access to ART in South Africa: The Role of Nurse Initiated Treatment" *South African Medical Journal* 100(4) (2010): 210.
87 K. McCarthy, M. Chersich, J. Vearey, G. Meyer-Rath, A. Jaffer, S. Simpwalo and W. Venter, "Good Treatment Outcomes among Foreigners Receiving Antiretroviral Therapy in Johannesburg, South Africa" *International Journal of STD & AIDS* 20(2009): 858-62.
88 Vearey, "Migration, Access to ART and Survivalist Livelihood Strategies."
89 Ibid., p. 369.
90 Ibid.
91 Ibid., p. 368.
92 Interview No 97, Orange Farm, Johannesburg ,3 September 2010.
93 Participant in Focus Group Discussion, Observatory, Cape Town, 4 September 2010.
94 SAHIVSOC, "Clinical Guidelines for Antiretroviral Therapy Management

for Displaced Populations: Southern Africa" Southern African HIV Clinicians Society and UNHCR, Johannesburg, 2007.

95 P. Mayers, "Teaching Medical Students on the Ethical Dimensions of Human Rights: Meeting the Challenge in South Africa" *Journal of Medical Ethics* 24(1998): 257-62; R. Preez, G. Pickworth and M. Van Rooyen, "Teaching Professionalism: A South African Perspective" *Medical Teacher* 29 (2007): 284-91; L. London and L. Baldwin-Ragaven, "Human Rights and Health: Challenges for Training Nurses in South Africa" *Curationis* 31 (2008): 5-18.

96 L. London, "'Issues of Equity are Also Issues of Rights': Lessons from Experiences in Southern Africa" *BMC Public Health* 7 (2007): 14.

97 Mawadza and Crush, "Metaphors of Migration."

98 Address by President JG Zuma on National Reconciliation Day, Tshwane, 16 December 2009 at http://www.thepresidency.gov.za/pebble.asp?relid=557

Migration Policy Series

1. *Covert Operations: Clandestine Migration, Temporary Work and Immigration Policy in South Africa* (1997) ISBN 1-874864-51-9
2. *Riding the Tiger: Lesotho Miners and Permanent Residence in South Africa* (1997) ISBN 1-874864-52-7
3. *International Migration, Immigrant Entrepreneurs and South Africa's Small Enterprise Economy* (1997) ISBN 1-874864-62-4
4. *Silenced by Nation Building: African Immigrants and Language Policy in the New South Africa* (1998) ISBN 1-874864-64-0
5. *Left Out in the Cold? Housing and Immigration in the New South Africa* (1998) ISBN 1-874864-68-3
6. *Trading Places: Cross-Border Traders and the South African Informal Sector* (1998) ISBN 1-874864-71-3
7. *Challenging Xenophobia: Myth and Realities about Cross-Border Migration in Southern Africa* (1998) ISBN 1-874864-70-5
8. *Sons of Mozambique: Mozambican Miners and Post-Apartheid South Africa* (1998) ISBN 1-874864-78-0
9. *Women on the Move: Gender and Cross-Border Migration to South Africa* (1998) ISBN 1-874864-82-9.
10. *Namibians on South Africa: Attitudes Towards Cross-Border Migration and Immigration Policy* (1998) ISBN 1-874864-84-5.
11. *Building Skills: Cross-Border Migrants and the South African Construction Industry* (1999) ISBN 1-874864-84-5
12. *Immigration & Education: International Students at South African Universities and Technikons* (1999) ISBN 1-874864-89-6
13. *The Lives and Times of African Immigrants in Post-Apartheid South Africa*

(1999) ISBN 1-874864-91-8

14. *Still Waiting for the Barbarians: South African Attitudes to Immigrants and Immigration* (1999) ISBN 1-874864-91-8
15. *Undermining Labour: Migrancy and Sub-contracting in the South African Gold Mining Industry* (1999) ISBN 1-874864-91-8
16. *Borderline Farming: Foreign Migrants in South African Commercial Agriculture* (2000) ISBN 1-874864-97-7
17. *Writing Xenophobia: Immigration and the Press in Post-Apartheid South Africa* (2000) ISBN 1-919798-01-3
18. *Losing Our Minds: Skills Migration and the South African Brain Drain* (2000) ISBN 1-919798-03-x
19. *Botswana: Migration Perspectives and Prospects* (2000) ISBN 1-919798-04-8
20. *The Brain Gain: Skilled Migrants and Immigration Policy in Post-Apartheid South Africa* (2000) ISBN 1-919798-14-5
21. *Cross-Border Raiding and Community Conflict in the Lesotho-South African Border Zone* (2001) ISBN 1-919798-16-1
22. *Immigration, Xenophobia and Human Rights in South Africa* (2001) ISBN 1-919798-30-7
23. *Gender and the Brain Drain from South Africa* (2001) ISBN 1-919798-35-8
24. *Spaces of Vulnerability: Migration and HIV/AIDS in South Africa* (2002) ISBN 1-919798-38-2
25. *Zimbabweans Who Move: Perspectives on International Migration in Zimbabwe* (2002) ISBN 1-919798-40-4
26. *The Border Within: The Future of the Lesotho-South African International Boundary* (2002) ISBN 1-919798-41-2
27. *Mobile Namibia: Migration Trends and Attitudes* (2002) ISBN 1-919798-44-7
28. *Changing Attitudes to Immigration and Refugee Policy in Botswana* (2003) ISBN 1-919798-47-1
29. *The New Brain Drain from Zimbabwe* (2003) ISBN 1-919798-48-X
30. *Regionalizing Xenophobia? Citizen Attitudes to Immigration and Refugee Policy in Southern Africa* (2004) ISBN 1-919798-53-6
31. *Migration, Sexuality and HIV/AIDS in Rural South Africa* (2004) ISBN 1-919798-63-3
32. *Swaziland Moves: Perceptions and Patterns of Modern Migration* (2004) ISBN 1-919798-67-6
33. *HIV/AIDS and Children's Migration in Southern Africa* (2004) ISBN 1-919798-70-6
34. *Medical Leave: The Exodus of Health Professionals from Zimbabwe* (2005) ISBN 1-919798-74-9

35. *Degrees of Uncertainty: Students and the Brain Drain in Southern Africa* (2005) ISBN 1-919798-84-6
36. *Restless Minds: South African Students and the Brain Drain* (2005) ISBN 1-919798-82-X
37. *Understanding Press Coverage of Cross-Border Migration in Southern Africa since 2000* (2005) ISBN 1-919798-91-9
38. *Northern Gateway: Cross-Border Migration Between Namibia and Angola* (2005) ISBN 1-919798-92-7
39. *Early Departures: The Emigration Potential of Zimbabwean Students* (2005) ISBN 1-919798-99-4
40. *Migration and Domestic Workers: Worlds of Work, Health and Mobility in Johannesburg* (2005) ISBN 1-920118-02-0
41. *The Quality of Migration Services Delivery in South Africa* (2005) ISBN 1-920118-03-9
42. *States of Vulnerability: The Future Brain Drain of Talent to South Africa* (2006) ISBN 1-920118-07-1
43. *Migration and Development in Mozambique: Poverty, Inequality and Survival* (2006) ISBN 1-920118-10-1
44. *Migration, Remittances and Development in Southern Africa* (2006) ISBN 1-920118-15-2
45. *Medical Recruiting: The Case of South African Health Care Professionals* (2007) ISBN 1-920118-47-0
46. *Voices From the Margins: Migrant Women's Experiences in Southern Africa* (2007) ISBN 1-920118-50-0
47. *The Haemorrhage of Health Professionals From South Africa: Medical Opinions* (2007) ISBN 978-1-920118-63-1
48. *The Quality of Immigration and Citizenship Services in Namibia* (2008) ISBN 978-1-920118-67-9
49. *Gender, Migration and Remittances in Southern Africa* (2008) ISBN 978-1-920118-70-9
50. *The Perfect Storm: The Realities of Xenophobia in Contemporary South Africa* (2008) ISBN 978-1-920118-71-6
51. *Migrant Remittances and Household Survival in Zimbabwe* (2009) ISBN 978-1-920118-92-1 2009
52. *Migration, Remittances and 'Development' in Lesotho* (2010) ISBN 978-1-920409-26-5
53. *Migration-Induced HIV and AIDS in Rural Mozambique and Swaziland* (2011) ISBN 978-1-920409-49-4

Co-Published by:

Southern African Migration Programme

Idasa and the University of Cape Town
Cape Town, South Africa

and

Southern African Research Centre
Kingston, Ontario, Canada

Open Society Initiative for Southern Africa

Johannesburg, South Africa